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FINAL REPORT

With comments and remarks by experts of claimants

requested by judgment of the 8th of July 2015 issued by the HAGUE DISTRICT COURT (Chamber of Commercial Affairs)

CASE NUMBER C/09/434236/HA ZA 13-17 and CASE NUMBER C/09/441930/HA ZA 13-476



Accident occurring in FARO Airport – Portugal 21st of December 1992

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ABBREVIATIONS

A <mark>cronym</mark>	Synonym	Translation
AIDS		Airborne Integrated Data System
AOM	AFM – FCOM	Airplane Operations Manual DC-10
ANA		Aeroportos e NavegaçAo Aerea, E.P.
ATC		Air Traffic Control
ATCO		Air Traffic Control Officer
ATS	AT/SC	Auto-Throttle System or Auto-Throttle / Speed Computer
A/P	P/A	Automatic pilot
BIM	FCOM	Basic Instructions Manual – Flight Crew Operating Manual
CCRL		Centro de Controle Regional de Lisboa
CMD		Command Mode (Auto-pilot function mode)
СТА	ATCO	Controlador de Triego Aereo (Air Traffic Control Officer)
CVR		Cockpit Voice Recorder
CWS		Control Wheel Steering
DFDR		Digital Flight Data Recorder
FAA		Federal Aviation Administration
F.E.	F/E	Flight Engineer
FL		Flight Level
F.O.	F/O	First Officer
ft		feet
fps		feet per second
ICAO		International Civil Aviation Organization
INMG	INM	Instituto Nacional de Meteorologia e Geofisica
IST		Instituto Superior Tecnico
kt.	kn	knots
ICAO		International Civil Aviation Organization
KNMI		Koninklijk Nederlands Meteorologisch Instituut or Roval
		Netherlands Meteorological Institut
MDC		McDonnell Douglas Corporation
mn	min	Minute
MP495	MP <mark>H</mark> 495	Martinair Flight involved in the accident (call sign)
NASB	NAIB	Netherlands Aviation Safety Board
	Dutch Aviation Safety Board	Netherlands Accident Investigation Bureau
	OvV	Raad voor de Luchtvaart
	RLD, RvDL, DSB	Onderzoeksraad Voor Veiligheid (Dutch Safety Board)
NLR		Nationaal Lucht- en Ruimtevaartlaboratorium
		National Aerospace Laboratory the Netherlands
nm	NM	Nautical mile [1852 m]
OvV		Onderzoeksraad Voor Veiligheid (Dutch Safety Board)
PF	PA	Pilot Flying or Pilot acting
PNF	PM	Pilot Not Flying or Pilot monitoring
PSU		Passenger Service Unit
RA		Radio Altitude
RoA	RvO	Official report issued by the Portuguese Commission of
		Investigation, Report of Accident
RvO		Report van Ongevol
SIO		Sistema Integrado de Observão Meteorologica
UTC		Universal Time Coordinated

0. PREAMBLE

0.1. GENERAL

In this final report, the word "Experts" refers exclusively to the three Experts appointed by the Court by the decision raised the 8th July 2015.

Any additional experts will be referred to, clearly, by their names, and their credentials will be indicated between brackets immediately following the first mentioning of their names.

The expression "Claimants advisors' team" shall be used to designate the authors of the "Review of interim report V17 with Remarks and Questions of Claimants " of 27 September 2016.

0.1.1. EXPERTS' COMPETENCIES.

No expert can claim that he has universal knowledge on all topics. Should it be necessary, he will refer to the best available competency provided by the appropriate specialist.

Moreover, this behavior is the foundation of a proper and well-conducted expertise.

The Experts want to underline that the Claimants advisors' team uses, exclusively and obviously without any contextual dimension, only the available textual information. These textual information do only provide factual results of the crew's action or effects due to the corresponding environment.

Assuming that the Claimants advisors' team came to the exact conclusions from the available textual information, it is obvious that they do not consider the Human Factors¹ dimension of the events.

The Experts, in the analysis they carried out, took this dimension into account and considered that the DASB (RvDL at the time of accident) (being part of the Commission of Investigation) did the same when it sent its comments to this Commission.

To be able to consider the importance of the Human Factors in a cockpit, it is necessary to have demonstrable operational experience and competencies in this field.

¹ Human Factors in its widest definition describes all the aspects of human performance when interacting with the (aviation) environment to influence the outcome of events

The Experts underline the fact that the Judge in charge decided to choose and appoint them on the basis of their individual CVs :

- An engineer and professor, internationally well-known in the field of Air Traffic Management (ATM), with a strong industry background, educating at leading universities including Human Factor concepts.
- Two airline pilots, both with more than 15000 hours of flight as captain, instructor and examiner, in charge during years to provide advices to their own national civil authority about flight safety.
- These two pilots have taught instructors and pilots on the "Human Factors" concepts since the beginning of their implementation in the captains' and first officers' training then for all personnel involved in airlines operations.
- One of these captains being first officer, captain, instructor and examiner on DC10-30 KSSU during more than 4500 hours of flight.

0.1.2. ANSWERS TO "REVIEW AND REMARKS AND QUESTIONS"

The Experts have studied carefully the "Review and Remarks & Question of Claimants of Interim Report V17" of 27th September 2016.

The large amount of non-relevant remarks within this report has lead to a huge confusion.

Consequently and in accordance with the Court's requirements, "Review and Remarks and Questions" (as provided by the Claimants advisors' team) will only be considered if they concern the actual content of the Experts' interim report V17; they should not be considered when the "Remarks and Questions" have already received an answer in that report.

The Experts want to underline that their mission is not to issue an opinion on the work of the Commission of Investigation.

It is obvious that the accident wouldn't have happened if the captain decided to go around at one moment during the approach to FARO, and, a fortiori, if he decided not to take off from Amsterdam.

But his job was to move the passengers from Amsterdam to Faro. This is probably an important human aspect in this file.

To simplify and clarify, the debatable flight can be divided the in two parts:

- The first one above 500 [ft]² elevation, which was handled by the crew with a correct airmanship, aside from an inappropriate correction of the wind during the interception and the final phase, flying so laterally displaced at the left of the radial 111°. During this phase, the immediate safety of the aircraft was never affected by the captain's decisions.
- and the one below 500 [ft] where the loss of control happened. The nondecision of go around under 500 [ft] is one of the major cause of the accident.

Many points and questions raised by the Claimant advisors' team, are related with facts without any relation with the loss of control under 500 [ft].

² Stabilization height mentioned in BIM MARTINAIR §3.4 APPROACH AND LANDING –Index 06

So, the Experts believe that providing answers to the questions of the Claimants advisors' team, referring to the part of the flight above 500 [ft] is not directly relevant.

0.1.3. DASB UNTIL 1994.

0.1.3.1. ROLE AND POSITION

The Experts must recall that the DASB was acting as a member of the Commission of Investigation and had consequently to respect the recommendations of the ICAO Annex 13 ("Aircraft Accident and Incident Investigation").

It is clearly indicated that the work of a Commission of Investigation is not to define liability but only to determine causes and/or contributing factors to avoid other accidents due to similar causes in the future.³

Consequently, the Experts' understanding of "the work in due care" of the DASB excludes all what concerns the determination of liability.

0.1.3.2. COMMUNICATION TO THE CLAIMANTS

The following text is a part of the preliminary introduction of the meeting of the 1st December 1994

« INFORMATION MEETING OF THE CIVIL AVIATION BOARD FOR THE VICTIMS AND THE FAMILIES OF THE FARO AVIATION DISASTER »

« The purpose of this meeting is to give information, information about the report, information about the role of the Civil Aviation Board, and in particular, this is what this afternoon is about, to give you the opportunity to ask the experts on this side of the table questions, factual questions.

What this meeting is not about - and I repeat - what this meeting is not about is answering questions about culpability, liability and financial issues. These questions will not be addressed because they do not fall under the remit of the Board. This is not the purpose of this meeting and the Board cannot answer such questions, so there's no point in asking them. »

The DASB representatives could not, ethically speaking, communicate with any party as long as the investigation was ongoing.

That is why Annex 13 specifies the conditions for the independence of these bodies.

Then, during the first meeting (11th August 1993) with the victims or the families, and before the issuance of the final report (15th November 1994), the DASB was bound by the obligation of non-disclosure, as member of the Commission of Investigation.

During the second meeting (1st December 1994), after the publication of the final report (15th November 1994), DASB was still bound by the content of the report itself,

³ ICAO Annex 13 : « Objective of the Investigation : 3.1 The sole objective of the investigation of an accident or incident shall be the prevention of accidents and incidents. It is not the purpose of this activity to apportion blame or liability »

unique official document. The Dutch authorities had the possibility to appoint experts to define liability and, in such context, never DASB could be part of these experts because of a possible conflict of interest.

The assessment of the DASB's work and/or behavior during the Investigation and after, during the meetings with the victims and families, will consequently follow strictly these considerations.

0.1.4. THE LIMITS OF THE MISSION OF THE EXPERTS

Based on the judgement of 8th July 2015 ref:C/09/434236 / HA ZA 13-17 en C/09/441930 / HA ZA 13-476, the mission of the expert has been limited to the general question in accordance with the following text inside quotes.

« The court has not yet formulated an opinion on the main argument referred to in 2.5, as it needs the advice of experts to be able to form such an opinion. The general question for the experts therefore is: did the <u>then</u> Civil Aviation Board handle the information available at the time regarding the aforementioned themes with due care? The court maintains this general question, which comprises all relevant aspects (and limitations to be taken into account), even after learning the responses of the Parties to the provisional and general opinion of the court on the questions given in the interlocutory decision. The experts need not conduct own investigations into the cause of the air crash, but rather provide an answer, based on their expertise, to the question whether or not the Board, in its <u>then</u> capacity, adequately processed the <u>then</u> known and available information. »

and

« (1) Did the Civil Aviation Board handle the information it had at the time regarding the aspects stated in 2.5 of this judgment with due care?

(2) Do you have other comments that may be relevant to the assessment of this case?"

The mission of the Experts is constricted on the actions in 1994 of "the then civil aviation Board", in its "then capacity adequately processed the then known and available information".

The mission of the Experts is not to evaluate the answers made by the DASB to the Horling's report in 2015, even though the study of all these questions is useful for a better analysis.

As already said, in accordance with the Court's requirements, "Review and Remarks and Questions" (as provided by the Claimants' advisors) will only be considered if they concern the actual content of the interim report V17; they should not be considered when the "Remarks and Questions" have already received an answer in that report.

No further answer⁴ to "Review and Remarks and Questions" will be provided if they do not meet these criteria.

⁴ At the begining of the analysis of the « Review and Remarks and Questions of Claimants of interim report V17 », the Experts will define precisely the use of the term « No comment » or « not relevant »

However, if it would turn out that a new point having a direct relation to the Experts' mission defined by the Court is raised by the Claimants' advisors, the Experts could provide a comment or answer, unless if this point is of no consequence on the Experts' conclusions.

0.2. THE "RAAD VOOR DE LUCHTVAART"

The Raad voor de Luchtvaart [Netherlands Aviation Safety Board] was established on 1st January 1937 further to the Luchtvaartrampenwet [Air Disaster Act], since repealed. At the time of the air accident, the Board did not have its own legal personality and was structured under the then Minister of Transport, Public Works and Water Management.

In 1993 the Luchtvaartrampenwet [Air Disaster Act] was replaced by the Luchtvaartongevallenwet [Air Accident Act] since repealed.

Further to the Wet Raad voor de Transportveiligheid [Transport Safety Board Act], since repealed, the tasks and activities of the Raad voor de Luchtvaart [Netherlands Aviation Safety Board] were transferred to the Raad voor de Transportveiligheid [Transport Safety Board] (see also sections 91 and 102 of this act for transitional provisions).

Subsequently, on 1st February 2005 the Raad voor de Transportveiligheid [Transport Safety Board] was transformed into the Onderzoeksraad voor veiligheid [Dutch Safety Board] see sections 87-90 of the Rijkswet Onderzoeksraad voor veiligheid [Dutch Safety Board Act].

0.3. WRITING CONVENTION

All samples from official documents are italicized and their sources indicated either in the text itself or in footnotes.

0.4. TIME REFERENCES

This question seems to be considered as an important issue in order to understand the last part of the flight MP495.

But the real question is, whatever the used time reference, whether this reference should be considered as a contributing factor to this accident.

The answer is obviously clear and negative; this is the reason why the Experts decided to close this question at the early beginning of their report.

Nevertheless, the Experts tried to understand how the Commission of Investigation considered this question during the investigation.

As it is not a crucial element to answer the questions raised by the Court of Justice, this analysis will be found in annex 8.1 of the present report.

For information, all along their report, the Experts will use the DFDR time as the main time reference because it is the cockpit reference time⁵ and also because it is the end of DFDR.

⁵ The DFDR time reference is the time provided by the Captain's clock in the cockpit.

1. GENERAL CONSIDERATIONS – THE MISSION

1.1. THE DECISION RAISED THE 8TH JULY 2015 :

" The court:

in both cases

- a) orders an investigation to be conducted by three experts;
- b) appoints as experts the aforementioned Mr L. Bloncourt, Mr J-L. Françon and Mr D. Kügler, in order to conduct an investigation and give a <u>written</u> and <u>substantiated</u> answer to the following questions:
 - 1) Did the Civil Aviation Board handle the information it had at the time regarding the aspects stated in 2.5 of this judgment with due care?
 - 2) Do you have other comments that may be relevant to the assessment of this case?"

1.2. THE MISSION

The Experts will only have to answer these two questions raised by the Court by establishing an in-depth comparison between the set of actions, performed by the Dutch Aviation Safety Board, that should have been taken, and those actions that have actually been taken.

To be sure, the Experts acting as described above will, at all time, keep in mind that the goal of the Commission of Investigation⁶ is not to lay blame and establish legal liability, but to establish facts to improve flight safety.

To avoid any misunderstanding, the Experts act to best of their knowledge to clarify and simplify their considerations and explanations. Furthermore, it is their goal to erase all the false or unnecessary considerations that may pollute the understanding of events.

⁶ As defined in chapter 3.2 of the present report

2. THE ACCIDENT – REMINDS

2.1. THE FACTS⁷

« On 21 December 1992, a DC-10-30F aircraft, registered in Netherland under the designation PH-MBN, with 327 Passengers and 13 crew members on board, was performing an approach to the runway 11 at Faro Airport, for a landing.

An active thunderstorm formation was approaching the airport.

The aircraft made a hard landing on the left-hand side of the runway 11.

The right landing gear fractured, followed by the separation of the right wing from the fuselage, starting a rotation of the aircraft along its longitudinal axis.

The aircraft slide to the right and off the runway, broke into two main sections and caught fire.

Several passengers and crewmembers were killed. »

2.2. THE AIRCRAFT

The aircraft involved was a DC-10-30CF, registered PH-MBN, serial number 46924, fuselage number 218, equipped with three CF6-50C engines and was delivered by McDonnell Douglass company in November 1975.

It is known as part of the fleet of the KSSU⁸ consortium.

The DC-10-30CF was a convertible cargo/passenger version of the DC-10-30.

⁷ Extract from the non-official translation of the official Portuguese report, issued in November 1994.

⁸ KSSU was a consortium made for maintenance purposes, by KLM, the former Swissair, SAS and the former UTA French Airlines.

3. THE CONVENTION OF CHICAGO⁹, THE ASSOCIATED DOCUMENTS AND THE COMMISSION OF INVESTIGATION

3.1. GENERAL CONSIDERATIONS AND THE ASSOCIATED DOCUMENTS

Within this chapter, the Experts want to point out the legal context of the international relationships between the member States of the ICAO¹⁰, which ratified the Convention of Chicago and, more precisely, the relationships between the member States involved in an investigation following an accident in aviation.

Please, refer to Annex 8.2 of the present report for a full analysis.

The Convention of Chicago issued 19 annexes¹¹, among them the annex 13 related to the Aircraft Accident Investigation.

3.2. THE ANNEX 13 AND THE COMMISSION OF INVESTIGATION

3.2.1. ACCORDING TO THE ICAO

In case of aviation accident or incident, under the direction of a main investigator designated by the country where the event took place, the accredited representatives of the following countries have the right to participate to the commission of investigation:

- The State of aircraft registration;
- The State of operator;
- The State of aircraft design;
- The State of aircraft manufacturer.

 ⁹ International convention related to civil international aviation signed the December 7th 1947, in Chicago
¹⁰ International Civil Aviation Organization created by the Convention of Chicago

¹¹ Annex 1: Personnel licensing

Annex 2: Rules of the Air

Annex 3: Meteorological Services for International Air Navigation

Annex 4: Aeronautical Charts

Annex 5: Units of Measurement to be Used in Air and Ground Operations

Annex 6: Operation of Aircraft

Annex 7: Aircraft Nationality and Registration Marks

Annex 8: Airworthiness of an Aircraft

Annex 9: Facilitation

Annex 10: Aeronautical telecommunications

Annex 11: Air Traffic Services

Annex 12: Search & Rescue

Annex 13: Aircraft Accident Investigation

Annex 14: Aerodromes

Annex 15: Aeronautical Information Services

Annex 16: Environmental Protection

Annex 17: Security – Safeguarding International Civil Aviation against acts of Unlawful Interference

Annex 18: Safe Transportation of Dangerous Goods by Air

Annex 19: Safety Management (SMS)

It is advised that the State of aircraft registration or the State of operator designate one or several advisors that they may suggest directly to the Commission of Investigation to assist the members of the Commission and the accredited representative.

Similarly, both States of aircraft design and of aircraft manufacturer will be able to designate one or several advisors that they may suggest to the Commission of Investigation to assist the members of the Commission and the accredited representative.¹².

Moreover, a third state may request to get involved in the investigation process if one of its citizens died in the accident. In this case, the State in charge of the investigation might give this third State the permission to designate its own expert; however, the expert will not be accredited and will only enjoy a certain set of prerogatives as clearly defined by the State charged with the investigation.

In this context, the composition of the Commission of Investigation officially designated to investigate the accident of the Martinair DC10 – Flight number MP495 – in FARO-Portugal conforms strictly to the ICAO's recommendations.

Under the appointed Portuguese Chief of the Commission of Investigation.¹³, this Commission was composed, among others, of:

- An accredited representative of the State of registration, which is, in this case, the same as the State issuing the airline operator certificate.¹⁴:
 - One or several officials appointed by the Dutch Aviation Safety Board;
- An accredited representative of the State of design, which is in this case, the same as the state of manufacturer:
 - One or several officials from the National Transportation Safety Board (NTSB) appointed by the Federal Aviation Administration of the USA.

Both these representatives had the status of "*accredited representatives*" as defined in the ICAO Annex 13 as followed:

- 5.25 Participation in the investigation shall confer entitlement to participate in all aspects of the investigation, under the control of the investigator-in-change, in particular to:
 - visit the scene of the accident;
 - examine the wreckage;
 - obtain witness information and suggest areas of questioning;
 - have full access to all relevant evidence as soon as possible;
 - receive copies of all pertinent documents;
 - participate in read-outs of recorded media;
 - participate in off-scene investigative activities such as component examinations, technical briefings, tests and simulations;

¹² Refer to next page for the definition of a « accredited representative »

¹³ Refer to Article 26 of the Chicago Convention - § 8.2 of this report.

¹⁴ This document is a mandatory document issued by the State involved, and required to be allowed to transport by air, passengers and goods.

- participate in investigation progress meetings including deliberations related to analysis, findings, causes and safety recommendations; and
- make submissions in respect of the various elements of the investigation.

To conclude, it conformed accurately to Annex 13:

- that the Commission of Investigation was placed under the direct responsibility of a Portuguese Official;
- that the State of aircraft registration (which also was the State of the operator) was being represented by one or several accredited representatives from the Dutch Aviation Safety Board;
- that the State of design (which is also the State of the manufacturer) was being represented by one or several accredited representatives from the NTSB;
- that the Commission of Investigation decided to use the services of the organizations acting as advisors and suggested by the accredited representatives; these organizations had to directly and precisely answer to the questions raised by the Commission of Investigation.

3.2.2. INITIAL ACTIONS OF THE PORTUGUESE AUTHORITIES

These are explained in detail in the official report of 1994.¹⁵.

3.2.2.1. NOTIFICATION

Notification of the accident was carried out as it was supposed to, as defined by Annex 13; the following actors were notified of the accident on the day of its occurrence:

- The Dutch Aviation Safety Board, which acts on behalf of both the State of aircraft, and the State of the operator;
- The Federal Aviation Administration (FAA USA), which was the administration that had certified the type of aircraft relevant to the case;
- The National Transportation Safety Board (NTSB USA), which was the US specialist of investigations in case of accident;
- McDonnell Douglas Company USA, which design then built the aircraft;
- The ICAO.

3.2.2.2. CONSTITUTION OF THE COMMISSION OF INVESTIGATION

Following the decision of the Director General of Civil Aviation of Portugal, this commission was put under the presidency of the Director of Aeronautic Personnel.¹⁶ who was assisted by five more people.

¹⁵ The RvA/RvO : Official report issued by the Portuguese authorities after the comments of the NTSB and the Dutch Aviation Safety Board

¹⁶ Mr Luis Alberto Figueira Lima Da Silva,

Following the suggestion of the President of the Commission of Investigation, the following were assembled to work together:

- A specialist in navigation aids;
- A specialist in medical and pathological issues;
- A specialist in air operations;
- A specialist in meteorology and navigation;
- A specialist in communications;
- The accredited representatives as indicated above.

Finally, the Commission of Investigation called on to the following experts or specialists to investigate:

- McDonnell Douglas [designer and manufacturer of the aircraft] to answer questions regarding the functioning of aircraft specific components;
- General Electric [designer and manufacturer of the engines] to answer questions regarding the functioning of the engines and associated parts;
- Rockwell International [designer of some parts of the aircraft's equipment, related to the navigation capability of the aircraft];
- Netherlands National Aerospace Laboratories (NLR) for some specific studies;
- Martinair (or its mother company KLM), for the transcription and translation of the content of the Cockpit Voice Recorder;
- The "Instituto Supérior Tecnico" to perform the metallurgic analysis;
- The "Instituto Nacional de Meteorologia" to perform the weather analysis;

The "Nationaal Lucht- en Ruimtevaartlaboratorium" (NLR) is the national Netherlands Aerospace Laboratory.

As an independent non-profit organization, the NLR is the aerospace-knowledge enterprise in the Netherlands and provides high-quality technical support to various areas of the aerospace sector.

This organization was in charge to analyze the meteorological context of the accident, and more precisely the potential occurrence of windshears and of microbursts, if any, at and around the airport.

The "Instituto Superior Tecnico" (IST) is one of the most prestigious engineering schools of Lisbon, and it was put in charge of analyzing the landing gear components of the DC10 wreckage.

The representatives of the Martinair as well as the representatives of its mother company, KLM, were entrusted with the transcription and the translation of the Cockpit Voice Recorder contents, and to provide the Commission of Investigation, with all relevant technical and operational documents deemed necessary.

4. ANALYSIS OF THE FLIGHT BY THE EXPERTS

The first question.¹⁷ raised in the mission entrusted to the Experts by the decision of the 8th of July 2015 does not cover the analysis of the flight itself but only, the action of the Dutch Aviation Safety Board during the investigation.

However, to answer the second question of the mission.¹⁸, the Experts have found it necessary to conduct this analysis for a better understanding of this accident and consequently, of the behavior of all entities involved in the investigation.

To make easier the reading of this report, the Experts have decided to group this analysis in the Annex 8.6 to this report.

¹⁷ Decision of 8th of July 2015: « Did the Civil Aviation Board handle the information it had at the time regarding the aspects stated in 2.5 of this judgment with due care? »

¹⁸ Decision of 8th of July 2015 : « Do you have other comments that may be relevant to the assessment of this case? »

5. THE OFFICIEL REPORT (RVO) OF THE COMMISSION OF INVESTIGATION

5.1. GENERAL CONSIDERATIONS

This report corresponds exactly to what was requested by the ICAO in chapter IV-4-4 of the document n°6920¹⁹.

According to this document, the report must be divided into five main sections.²⁰ :

- 1) factual information;
- 2) analysis;
- 3) conclusions;
- 4) safety recommendations;
- 5) annexes and appendices.

According to the ICAO Document n°6920, before the publication of the final report, it is recommended.²¹ that the Commission of Investigation consults with both authorities of registration and of construction of the aircraft since both have designated their own accredited representatives.

This recommended procedure is strictly the one implemented by the Portuguese Commission of Investigation when the comments of the Dutch Aviation Safety Board and the NTSB were requested.

5.2. THE CONTENT IN DETAIL

5.2.1. THE CAUSES OF THE ACCIDENT

5.2.1.1. ACCORDING TO THE OFFICIAL REPORT²²

« The commission of Investigation determined that the probable causes for the accident were:

- The high rate of descent in the final phase of the approach and the landing made on the right landing gear, which exceeded the structural limitations of the aircraft.
- The crosswind, which exceeded the aircraft limits and which occurred in the final phase of the approach and during landing.
- The combination of both factors determined stresses, which exceeded the structural limitations of the aircraft.

Contributing factors to the accident were:

• The instability of the approach.

¹⁹ Refer to annex 8.2.3 of the present report.

²⁰ Refer to annex 8.2.5 of the present report.

²¹ ICAO cannot issued rules but only « Standards and recommended practices »

²² Non official translation of the Report of the Commission of Investigation – page 129

- The premature power reduction, and the sustaining of this condition, probably due to crew action.
- The incorrect wind information delivered by Approach Control.
- The absence of an approach light system.
- The incorrect evaluation by the crew of the runway conditions.
- CWS mode being switched off at approx. 80 ft RA, causing the aircraft to be in manual control in a critical phase of the landing.
- The delayed action of the crew in increasing power.
- The degradation of the lift coefficient due to the heavy showers. »

5.2.1.2. A PROBLEM OF WORDING

From a purely technical point of view, and considering that both the analysis and the conclusion of the Commission of Investigation are true, the causes of the accident should have been presented as follow:

The cause:

The accident is a sum of conditions leading to a hard touchdown for which the aircraft was not designed, and therefore "not certified" (i.e. outside the certification limits). As a result, the right landing gear collapses and the right wing broke.

The contributing factors:

- An approach becoming unstable on short final.²³, just before the landing, apparently due to a change of the meteorological conditions and a high rate of descent;
- A premature reduction of thrust which aggravated the previous contributing factor;
- On very short final, a lack of decision to initiate a missed approach procedure.²⁴;
- An incorrect meteorological information.²⁵;
- A change in the flight management mode.²⁶ on very short final that might have disturbed the pilots' sensations regarding the responses of the aircraft.

5.2.1.3. COMMENTS BY THE EXPERTS

Whatever the cause of an accident might be, it is always the result of several factors, each of them having a various level of importance and impact.

For the Experts, the short final part of the approach roughly refers to be below 200 ft above the ground.
At this moment, the situation was guite confusing :

⁴ At this moment, the situation was quite confusing :

⁻ In his statement from 29.12.1992, the Captain said « I cannot remember that I have called to open the throttles ».

⁻ Refer also the F/E statement from 29.12.1992 « The Captain said "Go Aorund" and slammed the throttles open. »

²⁵ The ATC controller uses the runway 29 meterological information instead of the ones for runway 11.

²⁶ Disengagement of the CWS mode.

This is precisely what the Portuguese Commission of Investigation has underlined when it mentioned "a *non-standard trajectory*" and "a *variation of meteorological conditions*"; because both these factors have supposedly provoked an overrun of the aircraft's limitations.

In general, the main cause of the Faro accident was that the aircraft touched-down in a way and with a trajectory that did not follow, in very short final, the vertical standard flight path established by the applicable procedures.

It means, that one of the recommendations to improve the flight safety and issued by the Commission of Investigation as required by the Annex 13, should be to teach the pilots to initiate a missed approach in case of a non-stabilized approach and under a fixed height.

After the issuance of the draft accident report, published after the accident by the Commission of Investigation, the Dutch Aviation Safety Board proposed modifications to the content of this report to adjust the wording, but accepted the conclusions of the final report.

The Expert's mission is not to scrutinize the causes as indicated in the official report published by the Portuguese Commission of Investigation.

The Experts are specifically requested to consider the action of the Dutch Aviation Safety Board and to verify if "the Civil Aviation Board handle the information it had at the time regarding the aspects stated in 2.5 of this judgment with due care".

During the analysis of the documents provided, the Experts have forced themselves to stay away from the notions of "technical cause" and "responsibility" in the judicial sense.

This is also how the Experts evaluated the Dutch Aviation Safety Board's actions as well as answered the questions asked by the court.

5.2.2. THE DUTCH AVIATION SAFETY BOARD'S COMMENTS TO THE PORTUGUESE OFFICIAL REPORT

5.2.2.1. GENERAL COMMENTS

The first two paragraphs of the comments made on behalf of the Kingdom of the Netherlands by the Dutch Aviation Safety Board, are quite important.

It is important to clearly understand the meaning of these sentences to answer the question raised by the Court.

"The Aviation Safety Board is of the opinion that the Portuguese report, in general, correctly reflects the course of events leading to the accident.

The Board agrees with the factual information and generally agrees with the analysis and the conclusions drawn from it.".²⁷

There seems to be a general agreement from the Dutch Aviation Safety Board with the Portuguese official report; however, some differences exist when addressing certain details.

That means that the Dutch Aviation Safety Board agrees in general with the description of the events by the Commission of Investigation – based on the factual information – and more important, with the analysis and the conclusions made by this Commission.

As already mentioned in chapter 5.2.1.1, the Commission of Investigation determined that the probable causes.²⁸ for the accident were:

- The high rate of descent in the final phase of the approach and the landing made on the right landing gear, which exceeded the structural limitations of the aircraft.
- The crosswind, which exceeded the aircraft limits and which occurred in the final phase of the approach and during landing.
- The combination of both factors determined stresses, which exceeded the structural limitations of the aircraft.

It is important to note that the official Report of Accident (RoA) issued 31. October 1994 by the Commission of Investigation never uses the word "*windshear*" as the **cause** of the accident.

As already mentioned in chapter 5.2.1.1, the Commission of Investigation determined contributing factors.²⁹ to the accident as:

- The instability of the approach.
- The premature power reduction, and the sustaining of this condition, probably due to crew action.
- The incorrect wind information delivered by Approach Control.
- The absence of an approach light system.
- The incorrect evaluation by the crew of the runway conditions.
- CWS mode being switched off at approx. 80 ft RA, causing the aircraft to be in manual control in a critical phase of the landing.
- The delayed action of the crew in increasing power.
- The degradation of the lift coefficient due to the heavy showers. »

Again, the Official Report of Accident (RoA) issued 31. October 1994 issued by the Commission of Investigation never uses the word "*windshear*" as a **contributing factor** of the accident.

²⁷ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 1, issued on September 6th, 1994

²⁸ Official report of the Commission of Investigation

²⁹ Official report of the Commission of Investigation

The third paragraph of the Dutch comments confirms the content of the first paragraph and gives the actual opinion of the Dutch Aviation Safety Board: "*the analysis ... should be expanded*"³⁰

And why?

"To accurately determine the probable causes of the accident and the contributing factors".³¹

But what is the final purpose of this analysis?

"For the purpose of learning the lessons and taking accident prevention measures" ³²

The Dutch Aviation Safety Board agrees with the official conclusions in general, but they request a sharper analysis on the causes and contributing factors of the accident.

That being said, within the Portuguese Commission of Investigation they are not in charge to build up the analysis and issue the final report.

Ultimately, the Portuguese Commission of Investigation is the one making the conclusions and it is its choice to accept or refuse the remarks of the Dutch Aviation Safety Board.

5.2.2.2. THE WEATHER ASPECTS ACCORDING TO DUTCH AVIATION SAFETY BOARD

Indications from the Dutch Aviation Safety Board that "the crew ... has been fully aware about the prevailing weather at Faro airport".³³ are considered to be true.

The Experts have no evidence to confirm that the crew was not aware "of the extreme conditions at the time of the accident", as the Dutch Aviation Safety Board seems to suggest in the same sentence.³⁴.

As it happened, the crew indicated several times that the weather conditions were expected to be difficult and the Captain clearly spoke about a possible diversion towards Lisbon.³⁵.

³⁰ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 1, issued on September 6th, 1994

³¹ As indicated in the comments of the Kingdom of the Netherlands by the Aviation Safety Board

³² As indicated in the comments of the Kingdom of the Netherlands by the Aviation Safety Board

³³ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 1, issued on September 6th, 1994

³⁴ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 1, issued on September 6th, 1994

³⁵ Refer to CVR transcription

The Dutch Aviation Safety Board indicates that the crew was not informed of the existence of windshear, and, in the Expert's opinion, this is correct. At this time, there was no instrumentation related to windshear conditions available on-board, and the crew was only able to suppose that this kind of conditions could be effective because of the prevailing thunderstorms.

It must be noted that the SIO.³⁶ in principle possessed the means to analyze and to raise warnings in case of windshear, but it was solely based on the different variations of the wind at a given spot, and not based on a thorough comparison of winds measured by several sensors, themselves spread out around the airport.³⁷.

The Dutch Aviation Safety Board noticed correctly that information regarding weather conditions obtained during the flight, were similar to those prior to take-off (during flight preparation), with a rather constant wind of 15 to 20 knots coming from the south-east (150°).

The Experts agree with this observation.

The crew was aware of the presence of thunderstorms, even of the one that apparently disturbed the approach, because it was located only 8 to 12 nautical miles west of the airport.

The Dutch Aviation Safety Board confirms the analysis of the thunderstorms' effects, especially regarding turbulences and heavy showers.

The statements made by the Flight Engineer (F/E).³⁸ show that the flight goes through a stormy and bumpy area ("...experienced turbulences that could be classified as stronger than moderate.") at around 8 nautical miles during the right-hand turn towards the final path, before settling at the right axis for final approach.

The flashing of the feed pumps lights.³⁹ demonstrates a major flight path correction made by the automatic pilot to maintain the actual altitude.

In addition, the crew knew perfectly well that, in the event of thunderstorms, the occurrence of windshear was a true possibility.

Not only do they know it, they are also trained to face this type of events.⁴⁰

One only needs to look at the instruction manual of the company.

The instructions of the company are clear: Any crew must be able to react adequately in the event of conditions that suppose the presence of windshear, or in the event of conditions that simply disturb the final approach.

³⁶ SIO - Sistema Integrado de Observâo Meteorologica

³⁷ As installed in some specific airports in the USA, where windshears are frequent.

³⁸ Refer to F/E statement

³⁹ This refers to the fuel cue light associated with the fuel pumps located in the fuel tanks. It was recurrent that, in the DC10, these lights would flash whenever the fuel within the tanks would be accumulating at the rear of the tank, due to a strong nose up action. The nose up attitude is due to three simultaneous elements: the standard position of the DC10 when in approach or landing configuration (slats extended), the need for the autopilot to correct the flight path in order to maintain the required altitude whatever the turbulence associated to the thunderstorm, and the increase of attitude because of the turning in final.

⁴⁰ According to the Flight Crew Operating Manual (Martinair's BIM or KLM's FCOM)

The Experts estimate therefore, that the comment made by the Dutch Aviation Safety Board — "*the crew did not expect the existence of windshear phenomena*".⁴¹— is not fully appropriate.

From the Experts' point of view, the Dutch Aviation Safety Board insisted on the fact that the airport documentation.⁴² did not indicate "*specific weather phenomena*".

But insisting was pointless: only a very few airports around the world publish this kind of information.

The reason is simple: the position of thunderstorms overhead the airport was not accurately predictable at the time of accident.

It was possible to predict a general unstable condition with a possible occurrence of thunderstorms, but predicting the occurrence of a thunderstorm at a precise location was impossible at the time of the accident.

The Dutch Aviation Safety Board, later, commented on the choices made by the crew regarding both landing configuration and breaking distance.⁴³.

The Dutch Aviation Safety Board seems to agree with the crew's decision; and the Experts agree as well.

No information regarding the intensity of the showers was transmitted to the crew. The presence of thunderstorms makes the occurrence of strong showers more likely, but no communication speaks of it.

Visibility did not seem to be an issue during this approach; even though the F/O seems to lose the visual references at one point⁴⁴, putting the windshield wipers on "fast" mode apparently solving the problem of visibility.

The Experts consider, that the Dutch Aviation Safety Board is right not to highlight this specific point.

Regarding the wind information provided on board by the computers.⁴⁵, we will see in the annex related to aircraft's equipment.⁴⁶ that this information was important and that it could provide substantial help.

⁴¹ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 2, issued on September 6th, 1994

⁴² Faro's Airport Information Publications

⁴³ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 2, issued on September 6th, 1994

⁴⁴ Refer to CVR transcription

⁴⁵ Calculated by the R NAV system and provided on the performance page of the Computer Display Unit (CDU)

⁴⁶ Refer to chapter 8.6.3.5 of this report

The Dutch Aviation Safety Board is right to indicate.⁴⁷ that the use of the RNAV.⁴⁸ computed wind was "*not required*" in the Martinair's standard flight procedures.

However, not requiring it did not mean that it was forbidden.

What is forbidden is always clearly defined in the operational documentation.

The arrival at Faro on this day cannot be qualified as abnormal approach due to extreme weather conditions.

That being said, it is true that this approach was a <u>difficult</u> one, and all that could help the crew has to be positively considered.

For this crew (as for any crew), immediate information regarding the actual wind is always useful.⁴⁹.

And the CVR shows us that the Captain did not hesitate to use this computed wind information.

The assertion made by the Dutch Aviation Safety Board is true: the computed value of the wind (direction and intensity) should be wrong as soon as the aircraft does not fly symmetrically.⁵⁰.

Moreover, only the official indication provided by the ATC is considered as valid.

A major change of meteorological conditions actually occurred during the very last part of the approach, inducing an instability of the flight.

The Expert's investigation shows that this instability has started at around 800 feet height.⁵¹

The Dutch Aviation Safety Board considers this change of meteorological conditions to be a major contributing factor to the accident.

It relies on the studies conducted by the NLR to affirm that "the microburst, according to the calculations made by NLR, caused headwind to tailwind changes of a magnitude which would have triggered a windshear alert, if such a system had been installed in the aircraft."⁵²

The Experts prefer to be more cautious here. They estimate that the existence of windshear is possible, as the analysis by the NLR shows, but they do not feel confident enough to affirm that the intensity of this windshear was sufficient to be a contributing factor to the accident.

⁴⁷ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 3, issued on September 6th, 1994

⁴⁸ Navigation system of the KSSU DC10

⁴⁹ Nowadays, these information are constantly displayed on 'modern' instruments, and indicate both the direction and the strength of the wind. Instructions to engage in a missed approach procedure are even given if the computer estimates that it goes beyond the operational limits of the aircraft. All this did not exist at the time of the accident.

⁵⁰ Meanning wihout any slip angle.

⁵¹ Refer to chapter 8.6.5.3.1 – The vertical acceleration, in this report.

⁵² Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 4, issued on September 6th, 1994

However, it is very likely, not to say certain, that the weather conditions at arrival disturbed the approach and that the crew could simply not control the aircraft in that conditions.

5.2.2.3. THE USE OF THE WORD "FLOODED"

The definition of this word in the Oxford dictionary is as follows: *cover or submerge* (an area) with water in a flood.

As we will see in the annex 8.⁵³ of this report, this expression "Flooded" does not exist in the JAR-OPS 1⁵⁴.

At the time of the accident, the reference were the national rules. But it can be considered the JAR OPS1 as the reference to be applied because of the evolution of the European regulations and then the national ones.

The Dutch Aviation Safety Board used the expression "*contaminated runway*", and detailed the conditions associated with the term.

The Martinair documentations (or the KLM one) do not clearly define this term: they use the expression "*standing water*" as indicated in JAR-OPS 1.

As indicated by the Dutch Aviation Safety Board, the term "flooded" is used in the ICAO document n°4444.⁵⁵.

One must note that this document does not constitute a reference for pilots, and that it is more destined to be used by air traffic controllers (ATCO).

Here is the content of the ICAO Document n°4444 - chapter 11.4.3.4 – Messages containing information on aerodrome conditions:

11.4.3.4.1 Whenever information is provided on aerodrome conditions, this shall be done in a clear and concise manner so as to facilitate appreciation by the pilot of the situation described. It shall be issued whenever deemed necessary by the controller on duty in the interest of safety, or when requested by an aircraft. If the information is provided on the initiative of the controller, it shall be transmitted to each aircraft

⁵³ Refer to chapter 8.6.4.4.2 of this report

⁵⁴ Refer to the Annexes to understand why the Experts used the JAR OPS as a reference.

⁵⁵ ICAO Doc n°4444 : PANS ATM - Air Traffic Management - Procedures for Air Navigation Services

The Procedures for Air Navigation Services - Air Traffic Management (PANS-ATM) are the result of the progressive evolution of the Procedures for Air Navigation Services - Air Traffic Control (PANS-ATC) prepared by the Air Traffic Control Committee of the International Conference on North Atlantic Route Service Organization (Dublin, March 1946).

Originally applicable on a regional basis, the PANS-ATC became applicable on a worldwide basis on 1 February 1950.

The last edition of 2007 – the fifteenth – re-titled Procedures for Air Navigation Services — Air Traffic Management (PANS-ATM), provides for a comprehensive update of the procedures as well as a major reorganization of the contents. The new title reflects that provisions and procedures relating to safety management of air traffic services and to air traffic flow management are included.

concerned in sufficient time to enable the pilot to make proper use of the information.

- 11.4.3.4.2 Information that water is present on a runway shall be transmitted to each aircraft concerned, on the initiative of the controller, using the following terms:
 - DAMP: the surface shows a change of color due to moisture.
 - WET: the surface is soaked but there is no standing water.
 - WATER PATCHES: patches of standing water are visible.
 - FLOODED: extensive standing water is visible.

It appears that this information corresponds to what the controller can see from the tower.

Actually, the ATC controller (ATCO) does not know whether or not the crew will understand precisely what he means when he transmits information regarding the status of the runway.

Based on his training, he transmits the information to the crew to improve the flight safety: he should therefore ensure that he is well understood.

Such an issue today is always in-depth analyzed by specialists.⁵⁶: This type of issue is part of the investigation on verbal and non-verbal communication (in the larger meaning of the term.⁵⁷).

Such an analysis was not carried out at the time of the accident, except if a specific element calls for it, which was not evident in that instance.

The "flooded" information was transmitted at 07:28:17 UTC⁵⁸, which was a relatively critical moment:

- The aircraft was in the middle of the final turn procedure towards the final descent path for landing;
- The flight went through an active storm area, provoking turbulences "stronger than moderate" as said by the F/E;
- An important correction of the flight path just occurred, which resulted in the flashing of the fuel cue light⁵⁹.

Moreover, this information is transmitted about 5 minutes before landing. It is a long time taking in account the workload of the crew, which is performing the final approach using a VOR-DME procedure, next to an active stormy area.

Usually, an update on the prevailing weather conditions will be given by the ATCO to the landing aircraft when issuing the respective landing clearance.

⁵⁶ This is a huge chapter of the nowadays analysis of the Human Factors.

⁵⁷ Human interactive communication

⁵⁸ This information was also transmitted to the MP461, several minutes ago.

⁵⁹ The "fuel cue light" is an alert indicating that something wrong happens regarding the fuel systems. The pilots must then check the local panel to know precisely what is going on.

The landing clearance to MP495 was given at 07:31:44 UTC: "*cleared to land runway* one one, the wind one five zero, one five knots, maximum two zero".⁶⁰.

The previous description demonstrates that the crew members are mentally busy in the cockpit and that ensuring proper communication with the ATC is not their top priority at this particular moment.

The time gap.⁶¹ between the transmission of the "flooded" information and the Captain's answer is a huge element proving this assertion.

It is possible then that the Captain did not immediately understand the word "flooded".

Even though he did not understand it right away, he at least heard it.

This is what his answer "ROGER" suggests; "ROGER" is a general expression that means "I got it", and we cannot neglect it.

The Captain, in his statement, indicates what the term "flooded" might mean for him.⁶²: "*if the runway is actually flooded that means "standing water" to me. In that case, the breaking action in "poor" and the crosswind limit is reduced to 5 kt. In my mind this condition did not exist during our approach".*

The term "flooded" should then have resulted in a request for further information. But there was no further communication with ATC, related to this topic, which means that the Captain did not fully grasp the meaning and the importance of this word.

It is this last factor that enables the Experts, to agree with the Dutch Aviation Safety Board on this point.

The Experts consider that the Dutch Aviation Safety Board's position is valid since the information received by the pilots regarding the runway status did not strike them as important enough to make it a top priority in their assessment of the situation, and in the list of problems to solve.

5.2.2.4. THE APPROACH AND LANDING

Regarding the speed to be inserted if the ATS speed window.⁶³, and regarding the KLM flight crew operating manual, the REF speed.⁶⁴ was 139 knots.

The Experts think that:

 either the Captain considered steady wind conditions and in this case, the right command airspeed to be inserted was 144 knots (139 + 5 knots);

⁶⁰ Here, the Approach controller (ATCO) even transmitted to the aircraft the instantaneous wind from runway 29 instead of runway 11

⁶¹ 9 seconds (refer to CVR transcription)

⁶² Lijst 4-map-1-on-4 p.34 of the pdf document

⁶³ On the Multifunction control panel

⁶⁴ REF speed is the speed to manage during the approach, depending on the aircraft landing configuration. This speed is then modified according to the wind conditions.

• or, the Captain considered a gusting wind conditions and in this case, the right command airspeed to be inserted was 139 Knots.⁶⁵, having in mind that the ATS system will add automatically a 5 knots correction in case of gusts⁶⁶.

In both cases, the value of the resulting indicated airspeed to be monitored during the final approach is 144 knots.⁶⁷

And regarding the weather conditions prevailing at the landing time, the likely Captain's decision considering a gusting wind conditions is considered by the Experts as appropriate, leading to put 139 knots in the ATS window.

This difference of 5 knots between the selected speed in the ATS window and the speed to be monitored is not a cause of the accident.

The Dutch Aviation Safety Board is on the same position as the Commission of Investigation about the beginning of instability, calling it, *« oscillations in pitch, airspeed and engine power »*.⁶⁸.

The Dutch Aviation Safety Board regards the beginning of instability as being likely due to the first downburst⁶⁹ the aircraft had to go through.

The Dutch Aviation Safety Board believes that oscillations might have increased following the second and third microburst⁷⁰ that occurred during final approach, and also following interactions coming from the ATS and the pilot's control inputs.⁷¹.

The Experts confirm that instability increased until the loss of control. However, the Experts do not confirm the interactions of the ATS and the pilot's control inputs because neither the Dutch Aviation Safety Board nor the Commission of Investigation substantiated this theory.

The Experts agree and side with the Dutch Aviation Safety Board when it indicates that the instability did not force the aircraft to go beyond its operational limitations.

The Dutch Aviation Safety Board remains cautious regarding the vertical speed values as it seems that these values are merely computed, and not recorded by sensors.

⁶⁵ KLM FCOM § 3.3.5-03 : « During gusting wind conditions, the ATS will add up to a maximum of 5 knots to the ATS reference speed. »

⁶⁶ KLM FCOM § AOM 3.3.5-03 - Wind Correction Factor indirectly confirmed by Douglas in its response of February 12th, 1993 by Steven R. Lund. The target speed to manage was 144 knots meaning that the speed to put in the ATS window was 139 knots.

⁶⁷ Refer to the Captain's statement and to the Douglas response.

⁶⁸ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 5, issued on September 6th, 1994

⁶⁹ As defined by the NLR in its report CR94238C

⁷⁰ As defined by the NLR in its report CR94238C

⁷¹ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 5, issued on September 6th, 1994

The Experts agree here that such caution is appropriate.

The Dutch Aviation Safety Board's comments seem to indicate that what they identify as "*problems*".⁷² started at approximately 150 feet.

The Experts do not validate this statement because this phase of the trajectory is merely the continuation of the previous trajectory during which an uncontrolled, or mishandled, instability settled. Nevertheless, the Experts consider that severe problems started at 150 feet height.

Moreover, the Dutch Aviation Safety Board indicates that the thrust increase at around 102% at 07:32:40 UTC — 10 seconds before impact — is the result of the ATS's actions..⁷³/.⁷⁴

The Experts disagree with this assertion.

It seems that the specialists originally designated to lead this investigation preferred to remain cautious by avoiding declaring which one, between the ATS and the pilot, caused this thrust variation.

The thrust increase could also have be initiated by the pilots: this is at least the content of the statements made by the Captain and the F/E.

The Dutch Aviation Safety Board estimates that the Portuguese report is correct regarding the thrust decrease probably initiated by the ATS and confirmed by one of the pilots.

A lack of certainty about the thrust variation is the reason for the Experts to be cautious.

The Dutch Aviation Safety Board holds the F/O's actions on the controls.⁷⁵ responsible for the inclination leftward..⁷⁶

The flight analysis conducted by the Experts tends to agree with this statement.⁷⁷

The bank angle gradient to the left, surprises both pilots who react at the same time to control and reverse it, which ultimately created a banking inversion twice as strong.

It is technically possible that this probably strong action by the pilots provoked the automatic pilot to disengage the CWS mode.

⁷² Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 6, issued on September 6th, 1994

⁷³ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 6, issued on September 6th, 1994

⁷⁴ Refer to Captain's statement and F/E's statement.

⁷⁵ The Dutch Aviation Safety Board indicates that this action is on the rudder (23° to the left)

⁷⁶ Comments of the Kingdom of the Netherlands by the Aviation Safety Board, page 6, issued on September 6th, 1994

⁷⁷ Refer to chapter 8.6.5.3.2 of this report.

This is validated by the Dutch Aviation Safety Board.

However, a double-click⁷⁸, which was signaled and recorded by the CVR seems to prove that this disengagement was voluntary.

In case of automatic disengagement, only one click would have been recorded, and heard.

The Dutch Aviation Safety Board explains that both pilots might not have noticed since both were looking outside, and since the disengagement of the CWS mode is signaled only visually on the instrument panels.

It is possible that the signal was simply not seen by both pilots, but could have been seen by the F/E.

In such a case, it means that the double-click should be effective and it is the one which caused the Autopilot disengagement.

The statement according to which the disengagement of the autopilot (switching from CWS to MAN) occurred spontaneously is therefore not validated by the Experts.

The aircraft touchdown at 07:32:50 UTC and the NTSB indicates in its factual report of February 12th, 1993, that, at this exact moment, the flight data are as follows:

126 knots

• CAS:

Magnetic heading:

Pitch attitude:

- Roll angle:
- G forces:

116,72 ° + 8,79 ° + 5,62 ° (Right wing down) 1,9553

Note that for 162 tons.⁷⁹, the stall speed with Flaps 50° and slats extended to the land position, is 112 knots. At 126 knots, the aircraft is technically still able to fly.

The heading at touchdown is 117°, which a runway axis of 106°, meaning a crab angle of 11°.

⁷⁸ At 07 :32 :44 UTC and 80 ft according to the CVR transcription

⁷⁹ Estimated landing weight of the aircraft

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The Experts' conclusion should be that the crab angle could be a contributing factor to the collapse of the gear.

According to the official report, the high impact on landing (load factor -1,9555 G - and high vertical speed) are not only contributing factors but cause of the collapse of the gear.⁸⁰

The certification of the landing gear of the DC10 follows the FAA Part 25.473 « Landing load conditions and assumptions ».

These conditions are:

- (2) a limit descent velocity of 10 feet/second (600 feet/minute) at the design landing weight (Structural maxi landing weight) (the maximum weight for landing conditions at maximum descent velocity); and
- (3) a limit descent velocity of 6 feet/second (300 feet/minute) at the design take-off weight (Structural maximum take-off weight) (the maximum weight for landing conditions at a reduced descent velocity).

A vertical speed above 850 feet/minute as calculated by the Experts.⁸¹ is clearly beyond the limitations imposed by certification.

⁸⁰ The reference is the RvO 1.16.1 which, itself, refers to the fracture study presented in annex 10 of the official report.

⁸¹ Refer to chapter 8.6.4.6 of this report

5.2.3. THE DUTCH AVIATION SAFETY BOARD'S BEHAVIOR DURING THE INVESTIGATION

This is the main concern for the Experts because this question constitutes the core of the mission as defined by the Court.

The analysis and study of the archived documents put at the Experts' disposal shows an important involvement by the collaborators of the "*Netherlands Accident Investigation Bureau*" as called in the official report of the Portuguese Commission of Investigation.

We must bear in mind that the intervention by the Dutch Aviation Safety Board follows the ICAO Annex 13. It will be considered and will be able to take actions as an accredited representative who will be put directly under the responsibility of the President of the Commission of Investigation.

The problem that will arise for the collaborators of the Dutch Aviation Safety Board will be to remain independent from both the Dutch Authorities and the airlines involved.

5.2.3.1. KLM/MARTINAIR AND THE TRANSCRIPTION OF THE CVR

It is normal that most of the conversations in the cockpit going on are in Dutch language since the crew members are themselves Dutch natives (at least the pilots).

It is only in 2003 that a certain number of standards and recommended practices were published by the ICAO about the question of language to be used in a cockpit; these clarifications did not address general communication in the cockpit but only communications with ATC centers.

In our case, the use of the English language by the airline in its document concerning general operations makes us believe that English was the language to use.

Let us begin with the operational documents.

The document called "Basic Instructions Martinair" is written in English for the most part.

That being said, some paragraphs or chapters are in Dutch.

For instance, the rule addressing working hours and rest (chapter 1.1.2 of the BIM) is written in both Dutch and English.

This document establishes rules that ought to be always implemented regardless of the type of aircraft.

It also comes with annex documents edited by Martinair's mother company (KLM), which describe all technical characteristics and performances of the DC10.

It is worth noting that general rules do not address the use of various languages in the cockpit.

However, it is normal that crew members spontaneously use their native languages during non-technical conversations.

It appears that the crew was speaking English for all technical conversations and Dutch for general ones.

This therefore calls for a transcription of the CVR by people who are knowledgeable about Martinair's procedures (of the time) and who are completely fluent in Dutch.

The decision made by the Official Commission of Investigation to charge the Dutch Aviation Safety Board, acting also as accredited representative, to solve this question for a transcription of the CVR, is then logical.

5.2.3.2. NTSB AND THE DFDR ANALYSIS

In this case, the transcription and the interpretation of the flight data was assigned to specialists of the National Transportation Safety Board, also accredited representative of the USA/FAA.

This is logical because the designer of the system was an US company, and that the equipment the NTSB possesses is probably one of the best in the world.

5.2.3.3. THE OTHER SPECIFIC ANALYSIS

5.2.3.3.1. THE LANDING GEAR COLLAPSE

The investigation commission assigned the metallurgical analysis of the main gear's fracture to a Portuguese laboratory.⁸².

The conclusions appear in annex 10 of the Portuguese official report:

« The material of the various components of the landing gear had mechanical characteristics that meet the specifications provided by the manufacturer. All microscopic observations deeply documented in this report did not detect manufacturing defects, both internal and superficial or lack of homogeneity of the material. The material found was thus free from defects, homogeneous and the mechanical characteristics adjusted to the set of landing gear parts.

The macro and microscopic observations made in all critical parts and in selected areas of beginning of rupture clearly demonstrated that the rupture of gear parts, attachments and retraction mechanism was a static rupture, suddenly caused by an intense overload induced by the hard landing on the runway. The various localizations of sudden ruptures were detected and documented as well as a microscopic characterization of the mechanisms acting in breakage of parts, was conducted, which confirmed the above.

⁸² The "Instituto Supérior Tecnico";

Any fatigue pre-crack nor nucleation localization and fatigue cracking were detected. Therefore, the parts of the gear and associated motion mechanisms were, in the time of the accident, without fatigue or other defects and without internal fatigue damage. The rupture was due exclusively to the so strong impact on the gear during the hard landing that caused the overload that induced in the parts and in critical areas, instantaneous stress levels that exceeded the static ultimate strength of the material.

The approximate calculation of torsional moments created in the gear retraction mechanism at the instant of rupture has led to rather high values within the zone of plastic deformation of the material. This result confirms the conclusion mentioned above since the values obtained by bending moments could only be achieved in a violent overload stress caused by an impact applied suddenly. »

5.2.3.3.2. THE WEATHER CONDITIONS

The analysis of the meteorological situation was partially assigned to the KNMI (Koninklijk Nederlands Meteorologisch Instituut or Royal Netherlands Meteorological Institut)

This is a first analysis of the general meteorological situation.

A weather analysis was issued the 21st of January 1993 by the « Instituto Nacional de Meteorologia e Geofisica (Decision n° 29/92 issued on December 21st 1992). This analysis was also a general situation analysis showing a low-pressure area South-West of Portugal with heavy thunderstorms.

But the maps do not show an exceptional situation, that would alert pilots who face such instability in different regions of the world.

That being said, the general meteorological situation does seem to be unusual in the middle of December in Southern Europe.

Were there windshears during the final approach of the MP495?

This analysis was assigned to the NLR (Nationaal Lucht- en Ruimtevaartlaboratorium or Netherlands Aerospace Laboratory) as stated in a first contract requested by the "Netherlands Accident Investigation Bureau" (Initial report of NLR CR 93080 C as of 05 March 1993).

A second contract was initiated in order to complete the conclusions of the first report (NLR report CR94238C as of 06 July 1994).
The only thing we may add though is that the NLR has evaluated the wind during the final approach, and based their evaluation on an analysis of both vertical and horizontal accelerations.⁸³

The NLR has identified three situations of downbursts and areas of turbulence with microbursts; as it happened, it seems to be the third one that could really be of interest since the two previous ones were passed successfully, even though it caused instability of the aircraft on its trajectory.

For this last situation of downbursts and areas of turbulence with microbursts, it corresponds to a wind that would go from 170° to 190° (in average) in 20 seconds, and a speed of 27-28 knots to 45 knots.

This could very well explain the leaning leftward, but not necessarily, the brutal variation of bank angle.

These variations of wind, whatever its effects, are significant.



⁸³ The wind is not a recorded data as it is the result of a computing process. The only way to have an approximate value of the wind is to compare the route and speed of the aircraft by reference to the ground, to the heading and speed of the aircraft by reference to the air.

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The fact that the Dutch Aviation Safety Board proposed to hire the services of an outside laboratory (here NLR) perfectly follows the ICAO Annex 13.

As a last resort, the commission itself will pick and choose the experts or specialists it wants to provide help in the investigation.

The Commission of Investigation does not have any apparent reason that would force it to refuse the proposition of the Dutch Aviation Safety Board regarding the usage of the NLR's services — the latter having an already well established reputation.

As a consequence, the commission has no reason to reject the NLR's conclusions.

5.2.3.3.3. THE FUNCTIONING OF SOME AIRCRAFT EQUIPMENT.

It is rather usual to see a Commission of Investigation requesting the expertise and the assistance of an aircraft's manufacturer, or of an industrial company that designed and/or built a given system or a certain part of equipment.

It is also important to note that it is really not in the interest of the manufacturers to hide a weakness of their production. Such an action would not only make them responsible for any future problem, it would also seriously harm their reputation.

5.2.4. THE LETTER OF THE GENERAL MANAGER OF THE AVIATION AND MARITIME AFFAIRS AND THE ANSWER OF THE DUTCH AVIATION SAFETY BOARD

The General Director of Civil Aviation followed up with the Minister of Aerial and Maritime Affairs' instructions through this letter, dated on June 28th, 2011.

« In my letter of 17 May 2011, reference IENM/BSK-2011 /60723, I informed you that the analysis by AvioConsult of the air disaster at Faro in 1992 would be submitted to the Dutch Safety Board.

By now, Minister Schultz van Haegen has received the findings of the Board.

In the accompanying letter addressed to the Minister the chair of the Dutch Safety Board, T. Joustra, included the following assessment:

"It is the opinion of the Dutch Safety Board that this report does not present any new facts or insights in relation to the Faro disaster and that further investigations will not lead to further clarity or discovery of the truth.

I appreciate that this letter cannot remedy suffering and sorrow, but I hope that the relatives can obtain a degree of comfort from it. As I informed you earlier, the Director Aviation of my service, Mrs. Ellen Bien, is available for a personal meeting with Mr. and Mrs. Vroombout.

Please find enclosed the analysis of Dutch Safety Board of the report by AvioConsult.

I hope you will find this information useful. »

This letter is important in the context of the questions asked to the Experts; this is why the answers provided by the Dutch Aviation Safety Board ought to be evaluated.

Several points have been addressed throughout this report. The Experts provide answers to some questions regarding the use of the engines, the thrust management, and landing with locked wheels..⁸⁴

Other answers are more implicitly given about the objectivity of the Dutch Bureau of Investigation and Security.

The Dutch Aviation Safety Board proposed several modifications of the interim report V17, to the Commission of Investigation through different comments and remarks: the Commission did take or did not take them into account to issue the final report, showing a real independence.

One must not get confused between the nature of these two entities; in reality, one has full responsibility for the investigation (here: the Commission of Investigation) whereas the other one is just there to confirm, contradict and sometime help if necessary in order to shed more light on what happened (here: the Dutch Aviation Safety Board).

⁸⁴ Refer to chapter 8 of this report.

The experts have thoroughly analyzed the Dutch Aviation Safety Board's propositions and have at time corroborated, and at other time contradicted some of them.

One only needs to take a look at the draft accident report submitted by the Commission of Investigation to the Dutch Aviation Safety Board in which we can notice several potential errors that were later on corrected through the Dutch Aviation Safety Board's proposals.

6. ANSWERS TO THE COURT

This chapter is dedicated to the eleven points raised in the §2.5 of the judgment of the 8th of July 2015:

6.1. THE MICROBURST AND WINDSHEAR, THE CROSSWIND AND TAIL WIND COMPONENT ACCORDING TO THE REPORT OF ACCIDENT

It is undeniable that the aircraft has encountered destabilizing meteorological conditions during the last phase of its final approach.

The NLR has conducted two studies.⁸⁵ that both confirmed that the aircraft went through three windshears below 1000 feet/ground, after07:30:30 UTC.

The third windshear — through which the aircraft went at a very low altitude —has caused an important flight path deviation followed by a loss of control; the latter led to a descent rate way above the value that the landing gear could support.

The Experts estimate that these variations of speed and direction of the calculated wind must be considered, and as a result, they induced accelerations.⁸⁶ and turbulences.⁸⁷.

It seems likely that certain actions taken by the pilots had contributed to the increase of the rate of descent, which ultimately was excessive.

All that being said, it is not in the Dutch Aviation Safety Board competencies to requalify the NLR's conclusions. This makes no sense since the Dutch Aviation Safety Board has neither the expertise not the responsibility to do it.

6.2. THE (ALLEGED) OCCURRENCE OF A LATERAL MOVEMENT

All the elements analyzed by the Experts (the wind effects or the pilot's actions on the flight controls) lead to the same conclusion that there is a lateral movement towards the left of the runway.

It is a coherent conclusion with:

- The statement made by the pilots during their interviews, according to which the aircraft was on the runway extended center line at 200 feet height;
- The impact that occurred on the left-hand side of the runway as proven by the markings on the ground.

⁸⁵ Refer to NLR report CR 93080C pages 79 & 80 or NLR report CR94238C

⁸⁶ Although lower than the limit established by the ICAO in a published document that has been abrogated by the time of this report.

⁸⁷ Refer to passengers' or crew members' statements,

6.3. THE RATE OF DESCENT

The value of the descent rate was calculated by both the NLR and the NTSB in its analysis of recorded parameters on the DFDR.

Both have similar conclusions.

The Experts also obtained similar results.

Moreover, the analysis of the mechanical collapse of the right main landing gear illustrates the problem generated by an excessive vertical speed.⁸⁸

The Experts' mission is not to find out the origin of this vertical speed. Moreover, it is a normal job for an expert of a Commission of Investigation from which DASB is a part, to require the answer from the best specialist available for the related topic.⁸⁹ It is obviously not possible to deny the existence of a high vertical speed⁹⁰ at the time of the accident.

6.4. THE (ALLEGED) OCCURRENCE OF AN INTENTIONAL NAVIGATIONAL ERROR

If this question calls for the Expert to evaluate the decision of the crew to engage the last turn at 8 nautical miles, then the answer resides in the relevant Portuguese procedure published at the time.

The Experts' analysis as shown in paragraph 8.6.4.1 of this report, shows that the crew respected the published approach procedure, at least during initial and intermediate approach paths.

In addition, this flight path clearly avoided a very active stormy area, west of the airport for more or less 10 nautical miles.

6.5. THE (ALLEGED) MISSING OF CALLS BY THE CREW

If this question calls for the Experts to evaluate the fact that the crew forgot the "500 feet" call out, the Experts confirm that the crew forgot it even if it was partially corrected by the F/E' call out.

The instructions published by Martinair in its BIM indicate that, if the aircraft is not stabilized at this altitude, a missed approach procedure must be engaged. This specific instruction is customary in most airlines.

The pilots call this window the "stabilization floor".

⁸⁸ Referring to the conclusion of the "Instituto Supérior Tecnico" which was in charge to perform the metallurgic analysis;

⁸⁹ Refer to the Preamble of this final report.

⁹⁰ Vertical speed calculated and as recorded on the Aircraft condition monitoring system – NLR report CR 94238C page 50

The exact altitude of the stabilization floor⁹¹ may vary from one company to another, but it always has the same purpose.

What matters is not going through this window in a specific configuration, but to do it with respect to the trajectory as defined by the actual procedure.

The configuration will then be different whether the pilots carry-out a visual or an instrument approach.

Moreover, this stabilization floor means that all destabilization below this level should immediately be followed by a missed approach procedure.

In our case, the pilots should have initiated a missed approach procedure since the aircraft became destabilized, even at a very low altitude.

So, taking this into consideration, the fact that the pilots forgot to make the announcement verbally could be considered as a contributing factor to the accident: the announcement constitutes a verbal reminder of the procedure to follow, and it was not done.

6.6. KEEPING THE THROTTLE (TOO) CLOSED

There are two points to address regarding this question:

- First, the records show a strong thrust increase that reached a value comparable with a missed approach procedure;
- Then next, a decrease down to flight idle thrust.

Several scenarios have been mentioned but, for the Experts, it clearly appears that the increases in thrust were consequential to the destabilization, not a cause of it.

However, even though the thrust increase showed the pilot's intentions to go around, it also showed that he became aware of the situation but the variations of bank angle, whatever their origin, changed his order of priorities.

6.7. THE LANDING GEAR BREAKING OFF

There is no doubt whatsoever regarding this element; the Portuguese experts conducted analyses that are irrefutable:

- The material did not have any defect that could have weakened the gear's resistance;
- The maintenance of the system conformed with the constructor's instructions;
- The fracture occurred after a mechanical pressure on the landing gear that was beyond the metal's resistance capacity.

⁹¹ Make the differene in between the stabilization floor which is a reference for the handling of the plane and the MDA which is a reference for specific IMC approaches.

6.8. THE CREW'S INTERPRETATION – OR LACK THEREOF – OF THE TERM "FLOODED"

As explained before, the Experts estimate that analyzing the understanding of this word can be done using the largest sense of the term and cannot be dissociated from the "Human Factor" principles, which ought to be considered as a cause or a contributing factor of the accident.

This type of "Human Factor" analysis was at its early stage at the time of the accident, and no specific publication defined it clearly even though some airlines started to consider it in the flight safety policies.

The "flooded" information was transmitted to the crew around 5 minutes before expected landing.

It came at a moment when the pilots' workload was high:

- In the middle of the final turn;
- · Crossing of a storm west of the airport;
- With important variations of the flight parameters;
- And with important thrust variations and the flickering of fuel tank pumps lights indicating that the aircraft took at this precise moment, a substantial pitch attitude but within the AFM.⁹² limits.

The Experts note the delay, quite long (9 seconds), between the transmission of the "flooded" information by the ATCO and the answer from the crew, showing also that the crew was highly busy at this time.

From a "Human Factor" standpoint, it is then conceivable that the information "flooded".⁹³ was not fully perceived and understood, or actually even heard.

It is credible that the captain's answer was more of a reflex, which means that the information was not well understood.

On the other hand, one could suppose that the information was well heard and understood.

The Experts estimate that this information alone might not be sufficient to cancel the approach at this moment.

The final decision is what is called "a Captain's decision".

On this chapter regarding the meaning of "flooded", the Experts remind that the fact that the runway was or was not flooded is neither a direct cause nor a direct contributing factor of this accident.

⁹² Aircraft Flight Manual issued by the manufacturer.

⁹³ Refer to Captain's statement : « In my mind, this condition did not exist during our approach »

6.9. THE SUBSEQUENT STATEMENTS OF THE CAPTAIN AND HIS ACTIONS

The Experts want to remind, first, that they act at all time without any partiality, fully free from all possible influence or interpretation raised by any reports provided by any claimants or organizations.

The Experts want to highlight that they have been appointed because they are independent.

The Experts:

- understand this question as an evaluation of all captain's statements made after the accident itself;
- estimate that the Captain's statements are globally coherent with the objectives information including the DFDR and the CVR;
- note that the first part of the Captain's statement about the runway flooded begin by an "if" (*"if the runway is actually flooded that means "standing water" to me. In that case the breaking action in "poor" and the crosswind limit is reduced to 5 kt. In my mind this condition did not exist during our approach").;*
- note that the second part of the Captain's statement indicates that "In my mind, this condition did not exist during our approach";
- note that the "flooded" information has been sent at a moment when the workload inside the cockpit was high (see also chapter 5.2.2.3 of this report);
- would like to remind that the aim of the Dutch Aviation Safety Board, as accredited representative inside the Commission of Investigation acting under the ICAO Annex 13, was not to define a responsibility or a liability.

As a conclusion, the Expert estimate that the Captain's statements have been considered "in due care" by the Commission of Investigation and the Dutch Aviation Safety Board.

6.10. (ALLEGED INCORRECT) STATEMENTS OF MARTINAIR AND THE CIVIL AVIATION BOARD

6.10.1. MEETING OF 1993

A first information meeting was organized on 11th of August 1993: the result of this meeting was the submission of 143 questions asked by the Anthony Ruys Foundation to Martinair and the Dutch Aviation Safety Board.

All these questions were raised before the issuance of the official report on the accident by the Commission of Investigation.⁹⁴, and answered in November 18th, 1994 in writing..⁹⁵

⁹⁴ 31st October 1994

⁹⁵ Judgement of the 26th of February 2014 § 3.10

Consequently, the Experts consider as normal that the airline and the Dutch Aviation Safety Board, itself linked by an obligation of secrecy (to protect its independence because of its involvement as accredited representative in the Commission of Investigation), answer the questions after the issuance of the official report.

The Experts underline that the most part of these questions were not appropriate to the investigation itself but are related to liability and/or responsibility of the different actors, which is not the main purpose of such an investigation.

6.10.2. MEETING OF 1994

Another meeting took place on December 1st 1994.⁹⁶, after the issuance of the final report of the Commission of Investigation.

The purpose of this new meeting was to explain the content of this report, to provide information about the role of the Dutch Aviation Safety Board and to give opportunity to ask factual questions.

The Experts want to underline that the DASB or its representatives was bound by the conclusions of the Commission of Investigation.

The most important remarks raised by the families and victims were that the witnesses' statements were not considered by the Commission of Investigation.

The Experts have been provided with a document Dossier NA 2617 and Dossier NA 2622, merging the visual witnesses' statements.

The answers provided during the meeting to the families and victims were considered as not appropriate by the families and victims.

The Experts note that in some cases, the answers were not enough substantiated, mainly in the way an accident investigation is organized or conducted according to ICAO Annex 13.

They note the existence of contradictions in between the witnesses' statements but also contradictions between the statements and the objective recorded flight data.

6.11. THE LOCATION WHERE THE AIRCRAFT CRASHED.

The Experts assume that this question refers to the fact that the region of Faro could have been a cause, or a contributing factor of the accident.

⁹⁶ Judgement of the 26th of February 2014 § 3.11

General instructions regarding Faro airport do not provide any alert on this specific topic.

The Faro region was comparable, meteorologically speaking, to Lisbon or to other places on the other side of the Gibraltar strait, which are not well-known for their dangerous conditions.

This affirmation does not include stormy situations in which meteorological phenomenon such as windshear, microburst, or downburst can occur.

7. CONCLUSION

Let's remember that the question asked to the Experts was to define if, whether or not, the action of the Dutch Aviation Safety Board during the investigation that followed the accident of the 21st of December 1992 was in accordance with national and international regulations applicable at the time, and beyond mere regulation, if the investigation was well conducted, "with due care".

The Experts' mission is not to determine what or who was/were responsible or liable for the accident.

As demonstrated in several documents provided to the Experts, the Dutch Aviation Safety Board's behavior could have been improved, but was in accordance with standard investigation regulations.

In accordance with ICAO, the Dutch Aviation Safety Board did not lead the investigation but participated in the investigation under the authority of the appointed Portuguese Chief of the Commission of Investigation.

This is a crucial point:

- Any remark, any request for additional investigation, any analysis had to be approved by the official Commission of Investigation;
- Any other conclusion would be illegitimate if we consider the aim of an investigation as defined by international treaties and conventions.

Another important and interesting factor not to forget is that the Dutch Aviation Safety Board and its accredited representatives are subject to the same limitations and constraints as the Commission itself.

These limitations are established by the ICAO Annex 13.

It absolutely does not authorize to establish legal liability.

It only allows to establish causal chains or contributing factors as to anticipate other future potential issues and therefore improve the global flight safety.

The Dutch Aviation Safety Board proposed the involvement of third parties to bring a best-in-class professional expertise and answer questions raised by the Commission of Investigation; the Dutch Aviation Safety Board's behavior was in accordance with international norms, recommended practices and conventions.

In short, using the expertise of a Dutch laboratory like NLR or the expertise of the involved airline is in line with international recommendations.

There is no reason to objectively doubt the conclusions of these laboratories or organizations.

Nothing forced the Commission of Investigation to take into account these conclusions or even ask for different opinions if they started doubting the correctness of the answers given.

The proposals of modifications of the final official report were evaluated in detail by the Experts.

Some appeared to be adequate, and some other are not.

But only the official Commission of Investigation had the power to accept such proposals of modifications or reject them.

To conclude, the Experts consider that the Dutch Aviation Safety Board — through its actions, comments, and involvement into the investigation as an **accredited representative** of the Commission of Investigation — did not deviate from its responsibilities and fulfilled its obligations in due care as defined at the time of the accident in the ICAO Annex 13.

22th of April 2017

Laurent BLONCOURT

Dirk KÜGLER

Jean-Louis FRANÇON

8. ANNEXES

8.1. TIME REFERENCE

According to the transcription of the CVR, the touchdown occurred at 07:32:50 UTC, which seems to correspond to the DFDR recorded data as provided by the NTSB.

According to the official report, touchdown occurred at 07:33:20 UTC.⁹⁷, which shows a difference of 30 seconds.

In Annex #5 of the official report, named "TIME UTC", we note three references: Radar, Padrao (standard), and CVR.

The accident occurred at 07:32:49 on both "RADAR" and "CVR", but at 07:33:20 on "STANDARD".

Moreover, even though the gap between "RADAR" and "STANDARD" is constant, the gap between "RADAR" and "CVR" is not.

We can consequently read:

RADAR	STANDARD	CVR	Delta betwo and "ST	een "RADAR" "ANDARD"	Delta betw and	een "RADAR" "CVR"
06:51:29	06:52:00	06:49:49	MINUS	00:00:31	PLUS	00:01:40
06:55:09	06:55:40	06:53:38	MINUS	00:00:31	PLUS	00:01:31
06:57:37	06:58:05	06:56:09	MINUS	00:00:28	PLUS	00:01:28
07:00:09	07:00:40	06:58:51	MINUS	00:00:31	PLUS	00:01:18
07:03:39	07:04:10	07:02:29	MINUS	00:00:31	PLUS	00:01:10
07:05:14	07:05:45	07:04:08	MINUS	00:00:31	PLUS	00:01:06
07:09:14	07:09:45	07:08:18	MINUS	00:00:31	PLUS	00:00:56
07:19:39	07:20:10	07:19:09	MINUS	00:00:31	PLUS	00:00:30
07:23:34	07:24:05	07:23:14	MINUS	00:00:31	PLUS	00:00:20
07:27:49	07:28:20	07:27:40	MINUS	00:00:31	PLUS	00:00:09
07:32:49	07:33:20	07:32:49	MINUS	00:00:31	MINUS	00:00:00

We have to bear in mind that the equipment used for the CVR was not so reliable as it is now: this type of support was sensitive to heat and can easily become distended.

It is thus mandatory to adjust the CVR time reference with the standard UTC time. However, for a short period of time, such a synchronization is not obviously required. In the end, it seems that the Commission of Investigation has decided to use the "STANDARD" reference.

The Experts consider that the use of multiple time references used in the report had no consequences on the work of analysis done by the Commission of Investigation.

⁹⁷ Portuguese Official report page 21

8.2. THE CHICAGO CONVENTION AND ASSOCIATED DOCUMENTS

8.2.1. GENERAL CONSIDERATIONS

Two states have been involved in this accident:

- Portugal as the accident occurred on its territory; and
- The Kingdom of Netherlands because the operator's certification, its main base and the aircraft registration are under its responsibility.

The international aviation relations between States are governed by an Agreement signed in December 1944 and known as the « Chicago Convention ».

Portugal ratified this convention on 27th of February 1947 and the Kingdom of Netherlands, the 26th of March 1947.

The Chicago Convention founded the "International Civil Aviation Organization" (ICAO) and published 19 annexes dealing with all technical or non-technical issues related to the transport of passengers or cargo, first to ensure efficiency in international air services, but also to help to the development of this industry and the safety of its operations.

The ICAO has no power to establish regulations, but only to issue "standards and recommended practices", the so called SARP's.

Each member State commits – through the ratification of the Convention – to transpose these standards and recommended practices in its own legal and regulatory corpus.

These texts then become the applicable regulations for the operators certified by the respective member State.

In case of difference between the ICAO standards and recommended practices and the national implementation, the involved member State should inform the ICAO on the nature of these differences so that the other member states become aware of the resultant situation.

As it happened, neither Portugal nor the Kingdom of Netherlands changed their respective regulatory corpuses, which means that the ICAO standards remained fully applicable.

8.2.2. THE CHICAGO CONVENTION AND THE AIRCRAFT ACCIDENTS OR INCIDENTS

Here, it is most specifically the Article 26 of the Chicago convention that is relevant to us.

Article 26 - Investigation of accidents

In the event of an accident to an aircraft of a contracting State occurring in the territory of another contracting State, and involving death or serious injury, or indicating serious technical defect in the aircraft or air navigation facilities, the State in which the accident occurs will institute an Investigation into the circumstances of the accident, in accordance, so far as its laws permit, with the procedure which may be recommended by the International Civil Aviation Organization.

The State in which the aircraft is registered shall be given the opportunity to appoint observers to be present at the Investigation and the State holding the Investigation shall communicate the report and findings in the matter to that State.

The article is very clear: those responsible for the investigation are the authorities of the country where the accident occurs.

So in this case it is Portugal.

Furthermore, following Article 26 of the Chicago convention, both the work of investigation and the report are Portugal's sole responsibilities.

8.2.3. ASSOCIATED DOCUMENTS

It may turn out to be necessary for the ICAO to help its members fully understand the content of these annexes, but also understand how to successfully implement the standards and recommended practices it publishes.

The ICAO uses to this effect a set of documents comprising technical guidelines that are supposed to provide the help required to the good understanding of its norms and practices.

As it happens, in 2000 ICAO starts to publish a specific document (Doc n°9756), entitled "Manual of Aircraft Accident and Incident Investigation."

This document, divided in four volumes, explains precisely the procedure to follow to investigate in case of an accident.

The document $n^{\circ}9756$ is a successor of an older document — Doc $n^{\circ}6920$ — that was in force at the moment of the accident.

It is therefore the document n°6920 that will be used as the point of reference to evaluate the work the Commission of investigation — of which the Kingdom of the Netherlands is an accredited member; and it will be this same document that will be used to assess the potential comments and requests, fulfilled or not, from the Dutch Aviation Safety Board.

« The purpose of this manual is to encourage the uniform application of the Standards and Recommended Practices contained in Annex 13 and to provide information and guidance to States on the procedures, practices and techniques that can be used in aircraft accident investigations. Since accident investigations vary in complexity, a document of this kind cannot cover all eventualities. The more common techniques and processes, however, have been included.

Although this manual will be of use to experienced and inexperienced investigators alike, it is not a substitute for investigation training and experience.

This manual is issued in four separate parts as follows:

Part I — Organization and Planning;

Part II — Procedures and Checklists;

Part III — Investigation; and

Part IV — Reporting.

Because this manual deals with both accident and incident investigations and, for reasons of brevity, the term "accident investigation", as used herein, applies equally to "incident investigation".

The following ICAO documents provide additional information and guidance material on related subjects:

- Annex 13 Aircraft Accident and Incident Investigation;
- Annex 9 Facilitation
- Manual on Accident and Incident Investigation Policies and Procedures (Doc 9962);
- Manual on Regional Accident and Incident Investigation Organization (Doc 9946);
- Human Factors Training Manual (Doc 9683);
- Manual of Civil Aviation Medicine (Doc 8984);
- Hazards at Aircraft Accident Sites (Circular 315);
- Training Guidelines for Aircraft Accident Investigators (Circular 298); and
- Human Factors Digest No. 7 Investigation of Human Factors in Accidents and Incidents (Circular 240).

This manual, which supersedes the Manual of Aircraft Accident Investigation (Doc 6920).⁹⁸ in its entirety, will be amended periodically as new investigation techniques are developed and new information becomes available. »

8.2.4. THE INVESTIGATION'S OBJECTIVE IN CASE OF AN ACCIDENT

The ICAO Annex 13 defines clearly the objective of the investigation in case of accident:

GENERAL

- 1.1.1 The sole objective of an investigation into an aircraft accident or incident conducted under the provisions of Annex 13 shall be the prevention of accidents and incidents. Annex 13 also states that it is not the purpose of an investigation to apportion blame or liability. Any judicial or administrative proceedings to apportion blame or liability shall be separate from any investigation conducted under the provisions of Annex 13.
- 1.1.2 An aircraft accident or incident provides evidence of hazards or deficiencies within the aviation system. A well-conducted investigation should identify all immediate and underlying systemic causes and/or contributing factors of the accident or incident. The investigation may also reveal other hazards or deficiencies within the aviation system not directly connected with the causes of

⁹⁸ These preliminary considerations are the same on both documents N°6920 and N°9756

the accident. The emphasis of an aircraft accident or incident investigation shall be on determining why the accident or incident happened and on recommending appropriate safety actions aimed at avoiding the hazards or eliminating the deficiencies. A properly conducted accident investigation is an important method of accident prevention.

- 1.1.3 An investigation shall also determine the facts, conditions and circumstances pertaining to the survival or non-survival of the occupants of the aircraft. Recommendations for improvements to the crashworthiness of the aircraft are aimed at preventing or minimizing injuries to aircraft occupants in future accidents.
- 1.1.4 The Final Report, which is produced at the completion of an investigation, constitutes the official conclusions and record of the accident or incident.

As stated, the only objective is the accident prevention.

Annex 13 stipulates even more distinctly that the aim of the investigation is not to lay blame or to establish legal liability, be it civil or criminal.

As a consequence, all judicial or administrative procedure aiming at laying blame or establishing legal liability must be considered independent from any investigation that would follow indications as stated in Annex 13.

This means, without any doubt, that the investigation led by the Portuguese Commission of Investigation, to which the Dutch Aviation Safety Board has been appointed, had for sole objective to bring to light the technical or human causes of the accident; and once again, not to establish who is legally liable.

8.2.5. DETAILS ABOUT THE STRUCTURE OF AN OFFICIAL REPORT ACCORDING TO THE ICAO DOCUMENT N°6920.

According to this document, the report should encompass five major sections/chapters:

- 1) Known Facts;
 - a) Flight History (what happened during the flight))

We must bear in mind that only important events are to be written down in this section;

Recordings of the audio or of parameters constitute the main source of these chronological events. Other events will only be reported if they are considered an added value to the report.

- b) Injuries
- c) Damages to the aircraft
- d) Damages to the aircraft
- e) Information regarding the staff involved in the accident, especially the crew members

- f) Relevant technical information about the aircraft and relating to the loading of the aircraft
- g) Weather information
- h) Navigation assistance
- i) Communication
- *j)* Airdrome information (if applicable)
- k) Flight recorders
- *I)* Information pertaining to the wreck of the aircraft, and to markings on the wreck caused by hitting the ground
- m) Medical and pathological information
- n) Occurring of a fire and its consequences
- o) Survivability
- p) tests and searches conducted by the investigation commission
- q) Usage of new techniques/procedures (if applicable)
- 2) Analysis
- 3) Conclusion
 - a) Evidences
 - b) Causes that must not be a mere description of circumstances
- 4) Security recommendations
- 5) Annexes and appendices

8.3. LANDING LOAD CONDITIONS AND ASSUMPTIONS

FAR Part 25.473 - Landing load conditions and assumptions.

- (a) For the landing conditions specified in Part 25.479 to Part 25.485 the airplane is assumed to contact the ground—
 - (1) In the attitudes defined in Part 25.479 and Part 25.481;
 - (2) With a limit descent velocity of 10 fps at the design landing weight (the maximum weight for landing conditions at maximum descent velocity); and
 - (3) With a limit descent velocity of 6 fps at the design take-off weight (the maximum weight for landing conditions at a reduced descent velocity).
 - (4) The prescribed descent velocities may be modified if it is shown that the airplane has design features that make it impossible to develop these velocities.
- (b) Airplane lift, not exceeding airplane weight, may be assumed unless the presence of systems or procedures significantly affects the lift.
- (c) The method of analysis of airplane and landing gear loads must take into account at least the following elements:
 - (1) Landing gear dynamic characteristics.
 - (2) Spin-up and spring back.
 - (3) Rigid body response.
 - (4) Structural dynamic response of the airframe, if significant.
- (d) The limit inertia load factors corresponding to the required limit descent velocities must be validated by tests as defined in Part 25.723(a).
- (e) The coefficient of friction between the tires and the ground may be established by considering the effects of skidding velocity and tire pressure. However, this coefficient of friction need not be more than 0.8.

FAR Part 25.485 - Side load conditions.

In addition to Part 25.479(d)(2) the following conditions must be considered:

- (a) For the side load condition, the airplane is assumed to be in the level attitude with only the main wheels contacting the ground, in accordance with figure 5 of appendix A.
- (b) Side loads of 0.8 of the vertical reaction (on one side) acting inward and 0.6 of the vertical reaction (on the other side) acting outward must be combined with one-half of the maximum vertical ground reactions obtained in the level landing conditions.

These loads are assumed to be applied at the ground contact point and to be resisted by the inertia of the airplane.

The drag loads may be assumed to be zero.

8.4. COMMENTS REGARDING THE PROPOSITION OF CHANGES SENT BY THE DUTCH AVIATION SAFETY BOARD TO THE COMMISSION OF INVESTIGATION.⁹⁹

8.4.1. ESTABLISHED FACTS

chapter 3.1 indent 3 page 8	There were no indications of faults on the aircraft or its systems that could have contributed to the degradation of safety nor could have increased the workload on the crew during the final phase of the flight.	There is no proposal of change from the Dutch Aviation Safety Board about these two assertions. Even if the landing distance is not a contributing factor to the accident, the Experts evaluation is that the stowage of the reverser n°2 is a concern that the crew should have considered,
chapter 3.1 indent 4 page 8	The inoperative items at departure from Amsterdam, did not affect the aircraft operation.	according to the weather conditions.
Chapter 3.1 indent 12 page 9	The aircraft in the final phase of the approach passed a turbulence area associated with windshear and downburst phenomena, that initiated a longitudinal instability of the aircraft.	There is no proposal of change from the Dutch Aviation Safety Board about this assertion. The Experts estimate that instability is not the sole result of the meteorological conditions (thunderstorms) which included possible windshear and/or downburst.
chapter 3.1 indent 13 page 9	The crew was less aware of the turbulence and its consequences on the aircraft stability, due to the influence of the operation of the automatic flight control systems (ATS and CWS)	This is a suggestion of wording made by the Dutch Aviation Safety Board. The final position of the Commission was to change this wording but to keep the idea: « The use of the automatic flight control systems (ATS + CWS) could have degraded the crew's perception of the turbulence and the instability of the approach. »
		The Experts consider as valid the suggestion of the Dutch Aviation Safety Board because the crew was aware of the turbulence and about the active thunderstorms.

⁹⁹ Issued in the Comments of the Kingdom of the Netherlands by the Aviation Safety Board to the Report of Accident (RoA) – page 8 and followings, in September 1994.

chapter 3.1 indent 14 page 10	The aircraft was informed by Approach Control that the runway was flooded and the crew did not consider this information when determining braking action.	 The Dutch Aviation Safety Board suggestion is to change the last part of the sentence using the following wording : « when determining braking action ». The final position of the Commission was to change the whole sentence: « The aircraft was informed by Approach Control that the runway was flooded. The crew did not associate the term flooded with bad braking conditions (Poor), due to a lack of update of the ICAO phraseology in the Aircraft Operating Manual and Crew Training Manual. » The Experts' evaluation is that these two sentence should have been substantiated: the time gap between the issuance of information and the actual landing time is too important; the ICAO document 4444 was not issued to be used by crewmembers, but to be used by ATCO.
chapter 3.1 indent 15 page 10	At 07.32:15 UTC Approach Control transmitted the last wind information. Wind 150° - 15 kt, max. 20 kt.	The Experts want to underline that this information is false because of the following remark.
chapter 3.1 indent 16 page 10	Approach Control transmitted to the aircraft the instantaneous wind from runway 29 instead of runway 11.	In the final version of the conclusions (chapter 3.1), the Commission added a sentence: « <i>Faro Approach Control transmitted to the aircraft the instantaneous wind instead of the 2-minutes average wind and the wind from runway 29 instead of runway 11.</i> » The Experts consider the ICAO Doc 4444 as the reference for ATC controllers. There is no contradiction given that the text allows the ATC controller to report the significant variations. But the Experts consider that transmitting the runway 29 threshold wind is a professional mistake by the ATC controller

J.-L. Françon, L. Bloncourt, D. Kügler, Experts

chapter 3.1 indent 16 page 10	In view of the fast changing weather, in the last phase of the approach, the Board considers that this omission had no bearing on the accident, since, even if the correct selection for runway 11 had been made, the warning of the ATC controller would to all probability have come too late to be effective	Even if this Dutch Aviation Safety Board remark is true, the Experts consider that such a mistake made by an ATC controller is definitely not acceptable. Who knows the actual wind at the same time on runway 11 threshold and who can say that, with a right indication, the crew would decide or not to go around ?
chapter 3.1 indent 17 page 10	At 07:33:20 UTC, the accident occurred	The Experts note that the time reference does not match neither with CVR reference nor with DFDR one.
chapter 3.1 indent 19 page 10	Approach Control did not transmit to the aircraft the wind information on runway 11 that reached 220° with 35 kt between 07.32:40 and 07.33:30 UTC.	The Dutch Aviation Safety Board did not issue any comment on this sentence. This is the exact feeling of the Experts: 220° at 35 kt is the crosswind limit for the DC10. With a runway wet as indicated by the Captain and flooded as indicated by the ATC controller, a go- around decision would have been a highly probable consequence.
chapter 3.1 indent 21 page 11	The instability and the momentary visibility degradation in the final approach were not of such a magnitude that the crew should have made the decision to discontinue the approach.	The Dutch Aviation Safety Board asked to add or to modify part of this sentence: « <i>were not of such a magnitude that the crew should have made</i> » The Experts validate this Dutch Aviation Safety Board's proposal for the first part of the approach (above 200 ft AGL)
		The Commission changed the sentence, but in an opposite direction to that expected by the Dutch Aviation Safety Board: « The crew did not integrate information concerning the instability and the momentarily visibility degradation in the final phase of the approach, and having wrongly interpreted the communication of the runway condition (Flooded), did not take the decision to abandon the approach. » This final sentence makes clear that if the crew had understood the information about the runway conditions (« flooded »), it should have « take the decision to abandon the approach » Furthermore, this sentence, finally issued in the official report, is very important, given that the underlying philosophy allows the Commission to consider this lack of Captain's decision to go around as a contributing factor of the accident.

chapter 3.1 At 150 ft, the power was reduced to flight idle. In The Commission modified the sentence as follow: « At 150 ft (RA) power has been reduced to

indent 22 page 11	all probability, this power reduction was initiated by the ATS with a follow through by the F/O. Also the sustained flight idle thrust condition was most probably a result of action of the F/O. Normally, the ATS retard mode starts at 50 feet RA.	flight idle through ATS and kept at flight idle, probably by copilots' action. Under normal conditions the ATS retard mode starts at 50ft (RA). » Although it has been impossible to define the source of the reduction of thrust, the Experts validate the Dutch Aviation Safety Board suggestion but, in their opinion, the remaining doubt should have been underlined.
chapter 3.1 indent 23 page 11	The autopilot CWS mode disengaged at 80 ft, apparently non-intentional. There is no evidence that the crew noticed the resulting "autopilot red light" flashing signal.	 The Dutch Aviation Safety Board, writing such a sentence or modifying it, did not really consider the CVR transcription, indicating a double click at 07:32:44 UTC and 80 feet. The Commission modified the sentence as follow: <i>« At 80 ft RA the autopilot disengaged the CWS mode, apparently not intentionally. There are no clear indications that the crew became aware that the warning light for this condition was lit. »</i> The Experts do not validate neither the sentence suggested by the Dutch Aviation Safety Board nor the final one issued by the Commission. Both considered that the disengagement was not intentional but it is only an assumption. The Experts again refer to the CVR transcription.
chapter 3.1 indent 24 page 11	The sudden wind variation in direction and intensity during the last phase of the final approach created a cross-wind component which exceeded the aircraft limits in the AOM	The suggestion requested by the Dutch Aviation Safety Board ["during the last phase of the final approach"] is correct.

chapter 3.1 indent 25 page 11	Due to a premature, large and sustained power reduction and the sudden wind shift (tailwind component) in the final approach phase, the aircraft attained a rate of descent of 1000 ft/mn.	The final version of the sentence as issued in the official report has been: « The premature power reduction and the sudden wind variation probably increased the rate of descent, which reached values exceeding the operational limits of the aircraft. According to the values registered in the SIO, there has not been a significant variation of wind speed and direction in the last 20 seconds. » First, the thrust reduction did not create in itself a loss of control of the situation and the speed remained at all times above the stall speed. The wind variation did not increase, in itself, the vertical speed. At the opposite, it is possible that the pilot created himself the increase of vertical speed, acting on the controls to make a « positive touchdown » as required by the Captain during the briefing. The value of the left inboard elevator is obvious: One [1] second before the touchdown, a strong nose down action is recorded. As a consequence, the Experts do not validate any version, neither the one proposed by the Dutch Aviation Safety Board nor the one finally validated by the Commission.
chapter 3.1 indent 26 page 11	The crew intervention for power increase of the engines was too late to stop the high rate of descent.	No comment from the Dutch Aviation Safety Board. The Experts cannot validate this sentence. Out of stall conditions and, also, in specific conditions, the rate of descent is directly linked to the elevator. The thrust then allows the control of the speed. This sentence has been deleted in the final version and changed for the following: « <i>The captain's intervention during the whole approach seems to have been too passive, and</i> <i>concerning the last power increase, it came too late.</i> » The Experts do not validate this assertion of the Commission. The captain's intervention during the first part of the approach was highly professional, given that he was monitoring the descent as required by the airmanship for such a case.
chapter 3.1 indent 27 page 11	The fracture of the right landing gear was caused by the combination of the touchdown on the right hand aft wheel, the crab angle and the high rate of descent.	The final version of the sentence as issued in the official report has been: « The fracture of the right landing gear was caused by the combination of the touchdown on the right hand aft wheel, the crab angle and the high rate of descent. » Generally speaking, landing on a single gear is not abnormal: each time a landing is performed with crosswind, it is the case. That being said, the remark of the Dutch Aviation Safety Board is true.

8.4.2. CAUSES

Chapter	The commission of Investigation determined that	The Dutch Aviation Safety Board's suggestion is to insert the word "windshear", following the
3.2	the accident was initiated by:	NLR's conclusions.
	- a sudden and unexpected wind variation in	
page 13	direction and speed (windshear) in the final	The final version of the text is:
	stage of approach	« The Commission of Investigation determined that the probable causes for the accident were
	Subsequently a high rate of descent and an	- The high rate of descent in the final phase of the approach and the landing made on the
	extreme lateral displacement developed.	right landing gear, which exceeded the structural limitations of the aircraft.
	causing a hard landing on the right hand main	- The crosswind, which exceeded the aircrafts limits and which occurred in the final phase
	gear, which in combination with a considerable	of the approach and during landing.
	crab angle exceeded the aircraft structural	The combination of both factors determined stresses which exceeded the structural limitations of
	limitations.	the aircraft. »
		The Experts do not validate this wording.
		As previously indicated in 5.2.1.2, the cause of the accident is the contact with the ground in a
		manner not intended by the aircraft manufacturer and therefore "not certified".
		Indeed, if the Captain had initiated a go around procedure, there would probably have been no
		accident.
		The strength of the crosswind has nothing to do with ground contact. Subsequently, it would
		likely have made the lateral control difficult during the deceleration but in any case, at the time of
		touchdown. However, the cross wind has certainly destabilized the approach.
		It was also recorded that the pilot's action on the elevator could have induced a vertical speed
		exceeding the landing gear certification limits.

8.4.3. CONTRIBUTING FACTORS

chapter 3.2 page 13	From the forecast and the prevailing weather, the crew of MP495 did not expect the existence of windshear phenomena.	The Experts do not validate this Dutch Aviation Safety Board's proposition. From the crew members' point of view, associate the thunderstorms with the risks of windshear or, at least, with unstabilized approaches, is a basic knowledge. And the Martinair's FCOM obviously underlines these dangers.
		The Commission did not accept this suggestion of the Dutch Aviation Safety Board.
chapter 3.2	« The premature large power reduction and sustained flight idle thrust, most probable due to crew action »	The Commission changes its sentence for the following: « The premature large power reduction, and the sustaining of this condition, probably due to crew action »
page 13		The Dutch Aviation Safety Board, making this suggestion, does not exactly follow the NLR conclusions with indicates (Summary of the Doc 93080C from the NLR's report) that the "analysis concludes that at the end of the approach, the pilot flying probably did manually override the throttles to close them, possibly induced by an initial ATS command to reduce thrust"
		The final wording is not adequate because it has not been proven that this reduction is due to pilot's action.
chapter 3.2	CWS mode being disengaged at 80 ft RA causing the aircraft to be in manual control at a critical stage in the landing phase.	The Experts cannot validate this wording because there is no lowest altitude limitation to disengage the CWS mode. It is only an advice to let the pilot "feel the plane" before touchdown.
page 13		With some changes, the Commission validated the Dutch Aviation Safety Board 's suggestion

8.5. THE QUESTIONS RAISED BY AVIOCONSULT, THE OFFICIEL ANSWERS AND THE EXPERTS' COMMENTS ABOUT THESE ANSWERS.¹⁰⁰

Avioconsult report		Dutch Safety Board's answer (OvV response)	Experts' comments
Item 1	Introduction. After the catastrophic accident of Martinair DC-10- 30F at Faro airport, Portugal on 21 December 1992, investigations were undertaken by Portuguese investigators with the support of, among others, Dutch and American investigators. The activities of the Dutch investigators included reading out the Cockpit Voice Recorder (CVR), the American National Transportation Safety Board (NTSB) read out and reported on the flight data recorded by the Digital Flight Data Recorder (DFDR - the "black box").	No answer	The Avioconsult's assertion should be supplemented by the following: the Dutch Aviation Safety Board is not only the provider of the CVR transcription but it is first, an accredited representative of the Dutch authorities under the responsibility of the appointed director of the official Commission of Investigation. According to the ICAO Annex 13, it is the task of these representatives to help the Commission of Investigation to answer the raised questions, even using national specialists.
Item 2	The interim Accident Report (RvO, 21 July 1993) was translated into the English language and, as usual, was submitted for comments to, among others, the NTSB and the Dutch Raad voor de Luchtvaart (Dutch Aviation Safety Board). Both bodies submitted comments, after which the final version of the RvO was produced and published (6 September 1994).	Here it is suggested that the Portuguese report was translated by the Portuguese and then submitted for comments. That is not correct. The Portuguese report was submitted in the Portuguese language to both the NTSB and the Raad voor de Luchtvaart (Dutch Aviation Safety Board). In order to comment on it the report was then translated into English by the Dutch Aviation Safety Board (it is likely that the NTSB also did this for themselve). Hence the translated report states that the translation was done at the request of the Dutch Aviation Safety Board and each page of this English-language report states that it is an unofficial translation and that the text of the Portuguese is decisive The final report was published on 31 October 1994 in the Portuguese language.	The Experts performed their analysis, using the non- official translation but also the official version issued in Portuguese language.

¹⁰⁰ Attachment to the letter with reference IENM/BSK-2011/BB196. of 1st June 2011

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Item 3	At the request of some victims a new supplementary analysis was made of the cause of the accident, using the RvO of the Portuguese investigators and the letters from the NTSB included in the appendices to this report and flight data recorded by the DFDR, transcripts of the CVR, a report by the Netherlands National Aerospace Laboratory [Lucht- en Ruimtevaart Laboratorium] (NLR) and the comments by the Dutch Aviation Safety Board.		No comment
Item 4	Conclusions of the Committee of Investigation. The main conclusions in the Accident Report can be summarized as follows. An (*) means that the conclusion is disagreed with.	Hence (*) means that AvioConsult disagreed with the conclusion.	No comment
	 During approach the aircraft passed a turbulent zone associated with microburst and downburst phenomena which caused longitudinal instability of the aircraft (*); 	Portuguese report: The aircraft in the final phase of the approach crossed a turbulence area associated with microburst and downburst phenomena, that initiated a longitudinal instability of the aircraft. (A aeronave atravessou, na fase de aproximação uma zona de turbulência associada a fenómenos de microburst e downburst que desencadearam instabilidade longitudinal da aeronave.)	The Experts underline the use of the word « caused » in the Avioconsult's remarks and of the other word « initiated » in the Official report. In the final report, the sole valid according the ICAO annexe 13, the word used is « <i>desencadearam</i> » which meanning is « triggered ». A better translation of the portuguese content should have been « which triggered longitudinal instability » to avoid a confusion with the causes of accident as defined later in the official report.
		OvV response: AvioConsult concluded, on the basis of DFDR data, that there was no windshear.	The Experts developed this question of the presence of windshear as indicated by the NLR. The Dutch Aviation Safety Board is not responsible for the conclusions issued by the NLR.
		The analysis in the Portuguese final report stated that the approach controller did not give a windshear warning to the crew as earlier aircraft had not reported windshear. In the analysis it is	In the final version of the official Portuguese RvO, the word « Windshear » is not used, neither as a cause of the accident nor as a contributing factor. Nevertheless, the crossing of instability is effective

	also described that given the weather conditions there was a possibility of windshear near Faro. The analysis is continued by assuming that there was a windshear condition (what-if scenario) and the conclusion is drawn that the relevant procedures should have been applied.	and, even if this instability would not be classified as windshear or as «heavy» turbulence (moderate and/or severe), this instability generated a flight path instability.
	For the investigation of the event the NLR assessed the weather conditions. This assessment was made using the available FDR data together with a mathematical model of the aircraft. This study included the conclusion that there were indications of a 'microburst'. The conclusion of the NLR report was included in the Portuguese final report, but the final conclusion of the final report by the Portuguese authorities does not refer to windshear hence there is no difference in interpretation of the flight data as claimed by AvioConsult.	It is not the Dutch Aviation Safety Board's responsibility to validate the way the NLR issued its conclusions. The Commission of Investigation validated the conclusions, otherwise it should ask for another analysis performed by another expert.
	pilots caused the instability themselves by using rudder movements and CWS mode.	
	The Portuguese final report makes a link between the longitudinal instability (pitch angle stability), the CWS mode and the wind conditions at the time. It was also stated that the use of the automatic systems may have had an adverse effect on the perception by the crew of the turbulence and instability.	The Experts validate this part of the official report as it is obvious that a link must be done between instability, CWS and weather conditions. The weather conditions are a contributing factor for the flight path instability and obviously the CWS, linked to the flight controls, also.
	The use of the rudder and any movement thereof is not directly linked to the nose position (pitch) of the aircraft as stated by AvioConsult. The explanation given in the Portuguese report is much more likely.	The Experts are not really sure that Avioconsult made a linked between the nose position and the movement of the rudder.
	AvioConsult concluded that there was light turbulence	

	during the approach	
	This conclusion agrees with the final report where the final conclusion is drawn that turbulence associated with microburst and downburst phenomena caused longitudinal instability of the aircraft.	Not exactly. AvioConsult's assertion is that the flight only suffered light turbulence but neither windshear nor downburst.
	It is noted that although AvioConsult stated that there was only light turbulence, this turbulence was assessed differently in other parts of the AvioConsult report. For example, it was stated that the observations by the crew themselves and the turbulence occurring were reasons for a go-around.	The Experts validate the OvV remarks about the inconsistency of some AvioConsult's statements.
(2) The aircraft was informed by approach control that the runway was flooded, but the crew did not associate the term 'flooded' with poor braking conditions. Despite the available information about the instability and temporary worsening of visibility in the final stage of the approach and because of the incorrect interpretation of the information provided to them about the state of the runway (flooded) the crew did not decide to abort the approach;	Portuguese report: The aircraft was informed by Approach Control that the runway was flooded. The crew did not associate the term « flooded » with bad braking conditions (POOR), due to a lack of update of the ICAO phraseology in the Aircraft Operating Manual and Crew Training Manual. The crew did not integrate information concerning the instability and the momentarily visibility degradation in the final phase of the approach, and having wrongly interpreted the communication of the runway condition (flooded), did not take the decision to abandon the approach.	As indicated previously by the Experts, the used of the word « flooded » is only done in the ICAO Doc 4444 which is oriented for the ATC controllers. The Experts also developed this question and confirmed that the crew did not give to the word « Flooded » the ATC meaning, as this word was never used by the operator's documents.
	OvV response: The Portuguese report clearly stated that the crew did not interpret the term flooded correctly. AvioConsult did not state anything new. However, the AvioConsult report left out the text from the Portuguese report about not communicating wind information (220°, 35 knots; tailwind and an exceedance of the crosswind limit of the aircraft).	The Experts validate the OvV remark.
(3) At an altitude of 150 ft nower was reduced to	Portuguese report:	
		L

"flight idle", probably because of an action by the copilot. Under normal conditions the Auto Throttle System (ATS) starts the reduction at 50 ft. A premature reduction in power probably worsened the descent rate which reached values exceeding the operational limits of the aircraft (*). There was no significant change in the wind speed and wind direction in the final 20 seconds, according to the values recorded by the meteorological service;	At 150 ft (RA) power has been reduced to flight idle through ATS and kept at flight idle, probably by the copilot action. Under normal conditions the ATS retard mode starts at 50 ft (RA).	As already said, the Experts do not validate the official assertion related to the reduction of thrust. The rate of thrust variation is the same as if done by the ATS. It is then impossible to define definitely who initiate the thrust reduction. Precisely, the design of the system is to move back the thrust levers with 2°/sec then 3°/sec below 15ft and 6°/sec at touchdown. Nothing is proved but, NLR and NTSB indicate a manual reduction.
	The premature power reduction and the sudden wind variation probably increased the rate of descent, which reached values exceeding the operational limits of the aircraft.	Yes, but also a possible action by the pilot
	According to the values registered in the SIO, there has not been a significant variation of wind speed and direction in the last 20 seconds.	Yes. But the NLR expertise indicates such a wind variation.
	OvV response: AvioConsult did not agree with the fact that the descent rate exceeded the operational limit of the aircraft. In Section 2.2.3 Approach, the Portuguese investigation report stated that the actual descent rate of 1000 ft/minute exceeded the operational limit of 600 ft/min - specified in the Aircraft Operating Manual.	The NSTB and the NLR are on the same way, indicating that the vertical speed at touchdown was greater than the certification limits. The metallurgic expertise indicates also that the collapse of the gear is due to an excessive rate of descent.
	AvioConsult stated that the high descent rate was doubted. It was claimed that it was not indicated by the DFDR.	The Vertical speed is not recorded on the DFDR.
	It was also stated that it may be assumed that the descent rate was not abnormally high. According to AvioConsult the operational limit said to be specified in the Flight Crew Operational Manual was not exceeded.	The limits are not only an operational limit for the DC10 but a certification one: 600 ft/mn with the Maximum structural landing weight and 300 ft/mn with the maximum structural takeoff weight.
	AvioConsult did not address the limit said to be specified in the Aircraft Operational Manual, nor	That is also true even if the Experts do not validate the Dutch Aviation Safety Board's position stating that this

	the observed difference between the 2 manuals.	mistake (using RWY 29 information instead of RWY 11 information) is of no consequence.
	The SIO provides weather and wind information gathered by various sensors and is supplemented by observations by meteorologists. Every 30 seconds the average wind speed and wind direction during the preceding 2 minutes are stored. Sudden gusts or rapid changes in wind direction are not stored. Both the instantaneous and the average wind information are available in the traffic control tower. In this case, during the approach, the average wind was communicated to the crew but not the sudden change in wind. This was not stated by AvioConsult. It was also found that the wind measurements for runway 29 were used and communicated while runway 11 was used for the landing.	
(4) The collapse of the right-hand landing gear was due to a combination of the high descent rate with the correction for alignment at the time of contact with the runway (*).	 Portuguese report: The fracture of the right main landing gear was due to the combination of the high rate of descent and the drift correction taking place at the moment of contact with the runway. [This may be a translation issue: drift correction vs alignment correction] [translator's note: here and elsewhere we may have used "alignment" and "line-up" as synonyms] 	The metallurgic analysis defined that the collapse of the gear is due to excessive static forces, meaning that the main reason is the rate of descent. The translation of the expression « drift correction » should have been: « correction of the crab angle » The word « alignment » and « line-up » are not at all synonyms for a pilot: alignment is the maneuver initiated to cancel a crab angle during the flare and line-up is the maneuver performed by the pilot to prepare the aircraft for takeoff.
	The rupture happened exclusively due to the impact on landing which produced the overload	The Experts validate this OvV assertion and developed the respective analysis.

which matcred in the components and critical zones instantaneous levels of tension which exceeded the material static limit resistance. OvV response: In their analysis AvioConsult stated that it is suspected that the landing was made with braked wheels and that specifically that was the cause of the collapse of the landing gear. The report stated that the aircraft landed on the right-hand main landing gear. The report stated that the aircraft landed on the right-hand main landing gear. The report stated that the aircraft landed on the right-hand main landing gear. The report stated that the aircraft landed on the right-hand main landing gear. The report stated that the aircraft landed on the right-hand main landing gear. The range to the was not correctly aligned). The aircraft hit the nurway at a vertical speed of more than 300 fitninus which resulted in an acceleration of 1.9533 G. The damage to the wheels and tyres, as described in the Portuguese report, did not give any suggestions of blocked wheels and tyres, as described in the Portuguese report. Joint on give any suggestions of blocked wheels and tyres, as described in the approach. The same data shows that despile depressing the brake pedial the block and was. The suspicion of AvioConsult is not correct.				
Ovv response: In their analysis AvioConsult stated that it is suspected that the landing was made with braked wheels and that specifically that was the cause of the collapse of the landing gear. The report stated that the aircraft landed on the right-hand main landing gear with a nose position of 8.70° pich up and a roll angle of 5.62° to the right, and wind correction angle between 7° and 9° to the right, eliative to the center of the curvey, (i.e. the aircraft was not correctly aligned). The aircraft th the runway at a vertical speed of more than 900 thminute which resulted in an acceleration of 1953 G. The damage to the wheels and types, as described in the Portugues report, did not give any suggestions of blocked wheels during the borke pedal was occasionally depressed during the approx. The same data shows that despite depressing the brake pedal was occasionally depressed during the approx. The same data shows that despite depressing the brake pedal was occasionally depressed or of the aircraft is on the ground and the wheels. The suspicion of AvioConsult is not correct.			which induced in the components and critical zones instantaneous levels of tension which exceeded the material static limit resistance.	Landing with braked wheels (<i>aft wheels of the two wing gears</i>) is not possible as soon as the anti-skid system is operative.
Item 5 Conclusions of the Dutch Aviation Safety Board			OvV response: In their analysis AvioConsult stated that it is suspected that the landing was made with braked wheels and that specifically that was the cause of the collapse of the landing gear.	
Item 5 Conclusions of the Dutch Aviation Safety Board.			The report stated that the aircraft landed on the right-hand main landing gear with a nose position of 8.790° pitch up and a roll angle of 5.62° to the right, and wind correction angle between 7° and 9° to the right, relative to the center of the runway. (i.e. the aircraft was not correctly aligned). The aircraft hit the runway at a vertical speed of more than 900 ft/minute which resulted in an acceleration of 1.9533 G. The damage to the wheels and tyres, as described in the Portuguese report, did not give any suggestions of blocked wheels during the touchdown. According to the AIDS data (which stopped at 47 ft) the right-hand brake pedal was occasionally depressed during the approach. The same data shows that despite depressing the brake pedal the brake pressure remains 0. Information from the manufacturer of the aircraft	The Experts validate this OvV assertion
Item 5 Conclusions of the Dutch Aviation Safety Board			indicated that landing with blocked wheels is not possible given the system design. Only once the main landing gear of the aircraft is on the ground and the wheels are turning made the brake pressure available. Hence the aircraft cannot land with blocked wheels. The suspicion of AvioConsult is not correct.	
Item 5 Conclusions of the Dutch Aviation Safety Board				
	Item 5	Conclusions of the Dutch Aviation Safety Board .		

	The sudden variation in wind direction and speed during the final approach caused a crosswind component which exceeded the aircraft limits in the Airplane Operating Manual (*)	 OvV response: AvioConsult disputes this conclusion, but the conclusion (where it concerns the sudden variation) was not adopted in the Portuguese investigation report and is therefore not relevant to the assessment of the report. Incidentally, AvioConsult did not use the wind information at the time (220° at 35 knots) communicated by traffic control. The wind from this direction results, relative to the runway (106°) in a crosswind of 32 knots and 14 knots tailwind. The ACH specifies a maximum crosswind component of 30 knots. Hence the crosswind limit for a dry runway was also exceeded. Due to the premature major and sustained power reduction and the tailwind component during the final stage of the landing the descent rate of the aircraft reached approximately 1000 ft/min (*). OvV response: The effect of the power reduction on the descent rate was discussed earlier. The tailwind component increased the groundspeed. If the aircraft followed the same vertical path to the runway this would result in a higher descent rate. The collapse of the right-hand landing gear was caused by the combination of landing on the right hand aft wheel, the crab angle and the high rate of descent (*) OvV response: 	No comment
Item 6	1 Conclusions of this supplementary analysis. Despite the fact that significant data had been left out of or deleted from the ByO based on both the	OvV response: This comment, which also contains an accusation, is not based on facts and therefore speculative	The Experts validate the answer.
	information about the final stage of the flight presented in words, numbers and graphs by NTSB	The report indicated that 2 different flight recorders were used (the DFDR and the AIDS) for analysis	AIDS. Assuming that NTSB or a Commission of Investigation
in their DFDR Factual Report, and the factual information in the RvO it could be concluded, provisionally and objectively that:	and that one of these recorders, the AIDS (which is not crash-resistant) did not contain any data from an altitude of 47 ft due to damage to the tape. There is absolutely no indication that (the NTSB) erased anything.	can disregard data is a huge accusation! Remember the aim of ICAO Annex 13.	
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(1) the crew were informed at least four minutes before the landing that the runway was 'flooded' (covered in water), which would result in 'braking action poor'. The runway length required under these conditions would, according to the Landing Data Card calculated and drawn up by the crew themselves, be approximately 600 m (!) longer than the actual length of the runway. If the aircraft had landed correctly, then the aircraft	OvV response: The crew did indeed hear in time that the runway was 'flooded', however the crew did not make the línk to the 'poor' braking action. The Portuguese report attributes this to the fact that the Martinair Aircraft Operating Manual and the Martinair Crew Training Manual did not include the most recent ICAO terminology.	This statement is developed in 5.2.2.3	
would not have come to a halt in time on the flooded runway;	The crew had indeed calculated the required landing distance for all braking conditions, but they did not realize the fact that given flooded they should have assumed 'poor'.	Refer Experts' comments to the item 4 paragraph (2).	
	Whether or not the aircraft after landing would have come to a halt before the end of the runway cannot be stated with such certainty, but according to the calculation method used there was insufficient runway length available.	The Experts' opinion is that this question is of no importance because it is neither a direct cause nor a contributing factor to the accident itself.	
(2) that the crosswind limit for the condition of the runway at the time ('flooded') was exceeded;	OvV response: The crosswind limit (30 knots) was also exceeded for a dry runway if the current wind at the time, not communicated to the crew, had been used. Note: for braking conditions 'poor' a maximum crosswind of 5 knots was permitted.	Referring to the NLR analysis, the OvV's statement is true. But the Experts underline that the crew was not informed of such a crosswind limit exceedance.	
(3) that the approach at an altitude of 500 ft was not stable in terms of altitude, approach angle, speed and engine power, as specified in the Flight Crew Operating Manual (FCOM);	OvV response: In section 2.2.3. Approach, the Portuguese report indicated that the approach was not stable and referred to the Operations Manual; The company operations manual (BIM) strongly	According to the BIM, the flight should be stabilized at 500 ft and below, meaning that in case of destabilization occurring below 500 ft, the crewmember should have to perform a missed	

	recommends that in cases when an approach is not stabilized at 500 ft or below that level, the approach should be abandoned (a missed approach should be executed). The Portuguese final report also stated: The BIM does not contain any objective parameters when an approach is not stabilized, in particular during non-precision approaches. AvioConsult stated that the FCOM does include objective parameters relating to the stabilized approach, but does not address the potential	approach procedure. If the flight crew in a Non-Precision Approach has no visual reference to the runway at the Minimum Descent Altitude (MDA) – here 400ft. – a descent below must not be made (ICAO Annex 6).
	difference between the BIM and the FCOM.	
(4) the difference in the angle between the approach path followed by the aircraft and the prescribed approach radial in the horizontal plane was too large. No attempt was made to correct this, although time for this was available. The aircraft approached the runway at an excessive angle, not steering enough into the crosswind, and therefore did not reach the extension of the	OvV response: The approach procedure for runway 11 states that VOR radial 291° should be followed inbound (heading 111°). The specified approach has an angle of 5° to the runway heading (106°).	According to Captain's statement, the flight was established on the extended center line of the runway 11 at 200 ft. This seems confirmed by the radar position.
centre line of the runway;	The Portuguese Report stated that the 291° radial was passed while lining up before the approach. The aircraft flew north of this radial for some time. At a distance of 6 km of the runway threshold the aircraft passed this radial from north to south and then flew towards the extension of the center line of the runway.	This statement matches with the Official report. The Experts validate this conclusion.
	The figure shown below indicates that the deviations were limited and not such that they warrant AvioConsult's conclusion.	
(5) that the throttles of the three engines were pulled	OvV response:	
back or held back prematurely as a result of	The Portuguese report stated that:	The Experts do not validate the official statement as
which the engine speed and airspeed reduced too early and much too much during the last part	50 π (κA) power has been reduced to flight idle through TAS and kept at flight idle, probably by	the thrust reduction, whatever the reason, has begun earlier.
of the approach and the go-around initiated by	copilot's action. Under normal conditions the ATS	

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	the captain at the very last moment before the	retard mode starts at 50 ft (RA).	
	landing failed.	The captain's intervention during the whole approach seems to have been too passive, and concerning the last power increase, it became too late. [Translator's note: the following sentence was in italics and in Dutch: presumably it is the OVV response, rather than part of the Portuguese report.] The speed reduction, which was too early and to large, was not the cause of the failed go- around, it was the late intervention which was the	For the Experts, this statement is not true. The flight path monitoring was correct according to the airmanship. Even if this sentence was not adopted by the Commission of Investigation, the Experts validate this statement. The cause of the high rate of descent was not the too early or too large thrust reduction, but the too late intervention of the captain. And the crew members could have been able to
		problem.	initiate a missed approach procedure – obviously before the gear collapsed – thanks to the flight idle system.
	(6) that the standard manoeuvre to align the longitudinal axis of the aircraft up with the runway heading, to prevent a traversing landing, was initiated with significant hesitation too high and too early and the roll angle required for alignment with the runway was not adopted and maintained, as a result of which the aircraft was not aligned with the runway and landed with a drift angle.	OvV response: The Portuguese report did state that the aircraft landed with a drift angle. The report did not cover all the actions or failures to act by the pilot flying.	Neither the Commission of Investigation, nor the Dutch Aviation Safety Board indicate that the actions on the rudder have been initiated to de-crab the aircraft. The Experts consider that what is called « hesitation » is the evidence indicating that, when the pilot has begun his actions on the rudder, his probable intentions were not to de-crab the aircraft but, most probably, to improve, from his point of view, the control of the flight. Also, during such a landing with cross wind, the pilot's actions performed to maintain the runway centerline cannot, of course, remain constant because a gusting wind is not a steady wind!
	(7) that the aircraft landed half next to the runway and far beyond the touchdown zone and almost certainly with braked wheels as a result of which the forces on the landing gear increased enormously and resulted in its collapse.	OvV response: The Portuguese report stated that: the aircraft landed with the right-hand main landing gear on the left-hand side of the runway and that the marks made by the landing started in the touchdown zone, approximately 300 m beyond the runway threshold, i.e. not far beyond this zone. The AIDS data	 On the AvioConsult's comment, we have three considerations: Landing on the left part of the runway: The Experts validate this assertion but this is one of the factor allowing to explain the occurrence of a strong crossing wind from the right.

(8) that the graphs of the DFDR data and	indicated that the right-hand brake pedal was pressed down during the approach. The data of the AIDS recorder stopped at 47 feet. AvioConsult assumed that what was observed during the approach also occurred later during the landing. It also appears that they were not aware of the issue discussed under item 4 (4). Hence, this is a speculative remark.	 When we observe the rubber deposits left by the landings on a runway, they are not all concentrated in the same area or symmetrically on either side of the axis. It is not for nothing that a runway is 45 meters wide. Landing far beyond the touchdown zone: This assertion is wrong. The early first marks of touchdown are at around 300 meters from the threshold. First, a normal landing begins when the aircraft overflies the threshold of a runway at 50 feet. Considering a standard 5% slope approach, that means that the touchdown would occur at 300 meters beyond the threshold. According the ICAO Annex 14 which defines the standard marks on a runway, for an available landing distance of 2400 meters and more, the aiming point of touchdown should begin at 400 meters from the threshold and its length should be between 45 and 60 meters. The lateral spacing between 18 and 22,5 meters to minimize the contamination of the marking by rubber deposits. Landing with brake pedals depressed: This assertion is wrong.
(8) that the graphs of the DFDR data and discussions recorded on the CVR did not provide any indication that during the approach the aircraft passed through a windshear area. It was also found that the descent rate was normal and that the landing was not hard, but it was traversing. According to the ICAO definition the turbulence experienced was only light;	Portuguese report: According to the FDR data the aircraft landed with an acceleration of almost 2G and a vertical speed of more than 900 ft/minute. Both the crew and several others on board mentioned strong turbulence.	The Experts validate all the statements, either from the Commission of Investigation or from the Dutch Aviation Safety Board. They do not follow the AvioConsult assertion.

	OvV response: Here AvioConsult does not agree with the Portuguese authorities who stated in their report why they think that the weather can be described as turbulent with elements of windshear. However, a windshear warning was recorded shortly after the accident.	The recorded vertical acceleration values could be classified as low or very low according to an obsolete ICAO grid. But we must consider, at the same time, the vertical and lateral acceleration to have a good idea of actual turbulence experienced during the approach. The crewmembers' statements are in concordance with the passengers' ones. As indicated previously in this report, even if these turbulences would not be classified as moderate or severe, the problem is that they induced instability and this instability is obvious on the recorded data.
(9) that the crew did not act in accordance with the instructions for flying during or recovering from experienced windshear, and hence neither expected nor experienced windshear.	OvV response: Not acting in accordance with certain instructions cannot lead to the conclusion that the conditions under which these instructions apply did not occur.	For experts, it is surprising to read in the same sentence that the pilots did not respect the procedures in case of windshear and, at the same time, that they did not anticipate the existence of windshear. And moreover, AvioConsult constantly states that windshear conditions were not effective all along the approach. And in this context, the OvV response seems to be, at least appropriate.
(10) that from an altitude of 500 ft there were several reasons, based on the instructions, to make a go-around, which was not done.	OvV response: This conclusion by AvioConsult is correct. The Portuguese investigators also mentioned this in their report.	This comment is correct.
(11) that the throttles were operated incorrectly and not in accordance with the instructions and the autopilot was used inappropriately.	OvV response: The Portuguese report addressed the way in which the autopilot and throttles were used. However, the report did not qualify this with a value judgment such as 'inappropriately'.	The use of automatisms was strictly in accordance with the airline's procedures till the beginning of instability. Qualifying then the use of these automatisms as done is not on the line defined by the ICAO Annex13.
(12) that the crew did not make the approach in accordance with the prescribed Martinair	OvV response: This is not indicated by the information in the	The flight path was absolutely matching with the

	procedures and also not in accordance with the approach procedure and route prescribed by the Portuguese authorities.	Portuguese investigation report. The crew made a VOR approach. This is an approach which, under certain weather conditions, brings the aircraft in a position where a visual approach can be made. In this case, the crew could see the runway at approximately 4 nm from the airport. This procedure requires them to intercept the approach radial. This may be departed from once the runway is visible. Such procedures are designed with margins which allow for not immediately intercepting the approach radial. The wind and airspeed can always result in a tighter or wider curve during interception. During the approach it is permitted to descend to the minimum descent altitude (MOA) until other restrictions are specified. The glide path mentioned by AvioConsult is a glide path indicated by lamps next to the runway (PAPI). When following this glide path one is flying towards the runway at a 3° glide path. Given the above it cannot be concluded that the crew deviated from the specified approach procedures.	official procedures.
Item 7	Causes according to the Committee of Investigation. The most likely causes of the accident were:		
	 the high descent rate during the final stage of the approach made and the landing on the right-hand landing gear, further to which structural limits of the aircraft were exceeded (*); 	OvV response: The Portuguese report did state this. This was discussed above.	Already discussed
	(2) the crosswind, which exceeded aircraft limits, experienced during the final stage of the approach and landing,	OvV response: The Portuguese report did state this. This was discussed above.	Already discussed
	(3) Due to the combination of these two factors the structural limits of the aircraft were exceeded (*).	OvV response: AvioConsult stated that landing with braked wheels was considered to be a significant factor. Earlier it was stated that the suspicion that the landing was made with braked wheels is incorrect.	Already discussed

	(4) Contributory factors to the accident: The unstable approach, the premature engine reduction and maintaining this condition, probably due to crew action, the incorrect information about the wind from approach control, the incorrect assessment of the runway condition, the go-around attempt which was undertaken too late, and the reduction in wing lift due to the heavy rain.	 OvV response: The report did not mention a go-around attempt which was undertaken too late, but: The delayed action of the crew in increasing power. The Portuguese report also stated: The absence of an approach light system, and CWS mode being switched off at approx. 80 ft RA, causing the aircraft to be in manual control during a critical phase of the landing. Here, AvioConsult left out some issues which were included in the report. 	Already discussed The Experts validate the OvV response.
Item 8	Causes according to the Dutch Aviation Safety Board: A sudden and unexpected change in wind direction and speed (windshear) during the final stage of the approach (*). This was followed by a high descent rate and extreme lateral movement, which caused a hard landing on the right-hand main landing gear, which together with the significant crab angle exceeded the structural limits of the aircraft (*).	OvV response: This was not adopted in the Portuguese final report. OvV response: This was not adopted in the Portuguese final report.	The OvV answers are right.
Item 9	 Causes according to this supplementary analysis. The accident was caused because the crew: (1) ignored the current wind data communicated to them and read out on aircraft and ignored the condition of the runnow and did not represent to the supplementary and did not represent to the supplementary and the supplementary and the supplementary analysis. 	OvV response: According to Martinair procedures the wind	The Experts do not validate the OvV response nor the
	(implicitly) and diverting to an alternative airport. The crosswind limit was exceeded.	is expecting windshear. The facts do not indicate that the crew expected windshear. Additionally, AvioConsult tried to demonstrate that there was no windshear.	The use of the official wind is obviously mandatory because it is the only information available about the wind conditions near the threshold (refer to the position of the windsock near the threshold of a runway)

		The use of the RNAV wind on board cannot be a recommended procedure as the symmetrical conditions of flight are unknown. But the airmanship recommends the use of all available information to manage safely of an aircraft, then this use may be done with precautions. The existence of windshear is at all time possible when suffering a thunderstorm. But it was not obvious at this time to detect a windshear occurrence only using the flight instruments.
	The Portuguese investigation report stated that the crew did not associate the term 'Flooded' with braking action 'POOR'. Hence one cannot use the term ignore here. The last (uncommunicated) wind of 220° at 35 knots exceeded the crosswind limit for a runway with braking action 'good'. Based on the wind data available to the crew, no limits were exceeded for them. Here, the incorrect interpretation of the term 'Flooded' is essential.	This is true. But according to the « Human Factors » recommendations for the communications technics, the information was issued unfortunately at a bad time regarding the workload in the cockpit.
(2) during the final approach, deviated too much from the approach chart prescribed by the Portuguese authorities and were still not flying stably on the approach path at the altitude defined in the FCOM and, despite this, continued the approach and did not make the prescribed go-around.	OvV response: It is not indicated anywhere that the aircraft deviated 'too much' from the specified approach path. The last part of the approach was flown visually. The fact that the crew did not make a go-around was also described in the Portuguese report.	Already discussed above. The Experts validate the OvV response regarding the fact that the last part of the approach was flown visually.
(3) pulled the engine throttles back too early or held them back, as a result of which the go-around initiated at a low altitude failed.	OvV response: The link created here between pulling the throttles back too early and holding them back and the failure of the initiated go-around is unclear. In relation to this the report stated that the actions by the captain were too passive and that power was increased too late.	The Experts do not validate the AvioConsult assertion as it is at all time possible to initiate a « missed approach procedure » or what is called an « aborted landing procedure » (until reversers be extended).
(4) made serious, even fatal operating errors, both	OvV response:	

during the final approach and during landing, as a result of which the aircraft touched down partly to the side of the runway and with braked wheels, due to which structural limits were exceeded.	The Portuguese report addressed the actions or failures to act. This was done in the spirit of ICAO annex 13. The sole objective of the investigation of an accident, or incident shall be the prevention of accidents and incidents. It is not the purpose of this activity to apportion blame or liability. Using terms such as 'serious' and 'fatal errors' is incompatible with this.	The Experts validate the OvV response. They underline that the « serious, even fatal errors » are not precisely described in the AvioConsult report and that these expressions do not match with the aim of the ICAO Annex 13.
	As stated in 4.4, landing with blocked wheels is impossible for technical reasons. Depressing the brake pedals during the approach and landing is therefore not an operating error. The brake pedal is fitted to the rudder pedals. It is not unusual for the brake pedal to be depressed when operating the rudder pedals. This is especially relevant under conditions when many steering inputs are made using the rudder pedals. This happens during variable wind and turbulence.	The example of the « landing with the wheels braked » should be emphasized to sustain the Experts' opinion as the system itself is designed to precisely avoid this occurrence.
(5) handled the autopilot, autothrottle system and crosswind landing incompetently.	OvV response: This repeats of what was discussed under the previous item.	Same remark.

8.6. ANALYSIS OF THE FLIGHT BY THE EXPERTS

8.6.1. THE CREWMEMBERS

The three crew members are experienced and qualified for the aircraft type involved in this accident.

Generally speaking, a pilot who spends more than 600 hours flying a specific aircraft is subsequently considered as an expert, in regard to the "Human Factor" principles. In other words, the crew members have the capacity to react swiftly and naturally in case an unexpected event occurs during routine procedures.

Here is the individual experience of each crew member separately:

- For the Captain since March 1988:
 - A total of 1250 hours on DC10 in almost 5 years, which accounts for approximately 250 hours per year.¹⁰¹—a relatively small number. The Captain was Flight Instructor and involved in the DC10 department management.
- For the First Officer (F/O) since August 1989:
 - A total of 1800 hours on DC10 in which accounts for approximately 520 hours per year; and that is without counting the hours spent on flight simulator. This is a rather "normal" amount.
- For the Flight Engineer (F/E) active since early 1992:
 - Even though he recently joined Martinair, he is rather experienced on DC10 since he spent 1700 hours flying, among which he spent 1250 hours operating the aircraft as Flight Engineer.

Some extracts from the Flight Crew Training Manual used by Martinair (or KLM).¹⁰² explains the dangers and characteristics of windshears.

However, the documents provided to the experts does not indicate how the crew members were trained regarding this phenomenon, and therefore how knowledgeable the crew members were about windshears at the moment of the accident.

8.6.2. THE HUMAN FACTORS

An investigation that would be carried out according to nowadays' norms would address what is called "the Human Factors", which is inevitably an essential aspect of such cases.

¹⁰¹ Usually a crew member flies 600 to 700 hours a year. This small amount of flight hours is due to his position as instructor, which means a lot of flight simulator sessions and administrative work.

¹⁰² Flight Crew Reference Guide Chapter 5.1 Paragraph 5.5.1 - Gust and Paragraph 5.1.2 - Low level wind shear.

For this Faro accident, the investigation report is quite weak in this regard, which ultimately adds-up to the challenge posed to the Experts.

As a matter of fact, some of the documents provided by the claimants tend to lead to the conclusion that it was indeed the Human Factor — more precisely the reaction of the crew members — that is to be held in majority responsible for the accident.

Since 1970, ICAO published, in chapter 9 of its document n°6920, a recommendation as to take the Human Factor into account in case of an investigation.

Here is the text:

This chapter of the Manual of Aircraft Accident Investigation is intended as a general guide to an aircraft accident investigator on the contribution medical, pathological and human engineering specialists, in short the various « Human Factors » experts, may be able to make to an accident investigation and the nature of the work involved in their contribution. More detailed material is provided for the medical specialists themselves in the ICA0 medical manual and in other technical publications which, whilst technical in content, could be of value to aircraft accident investigators interested in this particular field.

The prime object of the Human Factors investigation is to obtain evidence as to the cause, sequence and effect of the accident through an examination of the operating crew, the cabin attendants and the passengers. Co-incidentally with the investigation, evidence as to identification will automatically emerge particularly if each examination is enhanced by the coordinated efforts of the Human Factors Group pathologist, police, odontologists, radiologists, etc.

Identification of the victims must not be regarded as an end in itself.

Identification is an essential part of the over-all aircraft accident investigation and it is expedient to integrate the identification of bodies with the post-mortem and autopsy examinations. It is for this reason that the subject of identification is dealt within some detail in this chapter.

The importance of the Human Factors investigation has been inadequately appreciated in the past; the evidence derived from the human beings concerned in an aircraft accident - be they crew or passengers, survivors or non-survivors - represents an integral part of the investigation as a whole. The purpose of this introduction and Section 9.2 is to outline the value of the medical investigation to aircraft accident investigators and to civil aviation administrations.

As we can see, the emphasis here is put on the pathological aspect, rather than on the psychological aspect, as a potential cause for an accident.

We therefore cannot hold the Commission of Investigation, and among it the Dutch Aviation Safety Board, responsible for not analyzing this specific issue.

We will need to wait for a few years.¹⁰³ before the psychological aspect of crew members can be effectively taken into account in the analysis of accidents that involve such complex systems, but also that touch upon other specialties.

¹⁰³ The first documents about what we call now the « Human Factors » were issued by ICAO, in 1994.

Admittedly, this accident comprises a good number of fascinating issues regarding the crew's psychology.

Let us ask a few questions without answering them (since it is not our mission):

- Why did one of the pilots seem to override the functioning of the ATS by decreasing or increasing the thrust in a way that seems to be not adequate to the specific conditions of this phase of the flight?
- Why did one of the pilots make such an excessive use of the rudder pedal at an altitude where such actions are neither usual, nor recommended?
- Why did a "go-around" procedure seems to be engaged but immediately stopped?

These questions are not directly listed as potential contributing factors to the accident.

Answers must not be given following mere impressions or without being properly illustrated.

The use of "probably" is not appropriate in such serious investigation work or in any type of comments, even 20 years after the facts.

8.6.3. THE AIRCRAFT

The DC10 was equipped with an autopilot system:

- under certain conditions, the system could land by itself and perform the taxingphase immediately after landing;
- the system could also fly "in transparency" through the option called "control wheel steering";
- it was equipped with an up-to-date.¹⁰⁴ navigation system, especially according to KSSU standard, to which the aircraft involved belonged. The aircraft was actually equipped with the first RNAV for area-navigation system.¹⁰⁵ of the time, which later on and to this day, became the standard equipment for all commercial aircraft.

8.6.3.1. THE CONTROL WHEEL STEERING OR CWS

The Portuguese report speaks of the aircraft's navigability without further elaboration whereas the question related to the handling of the CWS system was later deemed important in the origins of the accident.

This system was the ancestor of modern flight controls systems.

¹⁰⁴ When the DC10 performed its maiden flight in 1973, this equipment was really the best available in this industry. Even in 1992, it remains one of the well-equipped aircraft among the long range airliners.

¹⁰⁵ First stand-alone navigation system based on flight management computer systems and highly efficient flight directors and autopilots.

It allowed great accuracy but also provided great flight stability by watering-down excessive orders given to the flight control systems.

How did it work?

- CWS was a specific mode of the autopilot design to maintain two elements of the flight: the pitch and the roll of the aircraft.
- When switching-on the CWS, and without even needing to use the control column, the autopilot would maintain these two elements until it was given the signal to do otherwise.
- Variations in trajectory would from that point, only depend on outside meteorological disturbances.

How did the pilot give his orders to the autopilot?

- A component placed in the control column allowed to measure the pressure applied by the pilot on the column, either to pitch or to roll, and it transmitted these signals to the autopilot computer.
- The computer then took the measures necessary to activate the adequate control surfaces (ailerons and/or elevators), and as a reverse effect, physically moved back the control column.
- The control column was then moving independently from the pilots, as it was in fact following the activation of certain flight control surfaces by the autopilot.
- When switch-on, this process functioned continuously which enabled flying the aircraft through the autopilot "in transparency".
- As we can understand through the explanation above, the position of the control column was consistently being synchronized with the position of the control surfaces as both were linked by cables.
- It existed of course a certain flexibility in the system, which was ensured by shock absorbers and springs that prevented backlashes from activation or deactivation of the CWS.
- Nevertheless, pilot instructions indicated specifically not to exert any type of pressure on the control column at the moment of activation, or deactivation, of the CWS in order to avoid any bump.
- It does not mean that the plane could become uncontrollable or could have brutal reactions. If it ever was the case, how could we imagine such a system being approved and certified?

How did the pilots activate or deactivate the CWS system?

- The activation was done by moving the autopilot control lever from the MAN position to the CWS position; this was done by the pilot himself of course.
- The transition from CMD (autopilot engaged) to CWS can only be done manually by the pilot.
- Any action on the disengagement "reflex" push button on the control column, will cause a full disengagement of the autopilot (lever on MAN) and the appropriate visual alarm of disengagement (A/P red) would turn themselves on. A second action on this "reflex" push-button will extinguish the warning lights. A rapid double click on this push button will disengage the autopilot directly to MAN mode without any warning light illumination.

On DC10, there was no comparison on the forces applied by one pilot by reference to the other what is called a double-input.

This notion was brought by Airbus.¹⁰⁶ because of the use of joysticks not mechanically synchronized.

On the DC10, it is not the case because the control columns are mechanically linked to each other, and all actions that a pilot might take on his own column is felt by the other pilot in his own column.

There is no double-input on DC10.

That being said, there still was the possibility to disengage the autopilot, functioning in CMD or CWS mode, by a violent manipulation of the column.

For instance, in the case that the autopilot induced a spurious order because of a parasite signal and, as a consequence, engaged in a non-coherent maneuver, the pilots had the possibility to override the autopilot by an adequate manipulation of the control column which would provoke an automatic disengagement of the autopilot—associated with the visual alarms we mentioned earlier.

Usually, the DC10 was managed with both CWS systems always activated during the flight when the autopilot was not in CMD mode.

Once in final approach, the minimum altitude at which the CMD mode must be disengaged is 500 ft^{107} , at the latest. It was then possible to fly the aircraft either in CWS or in MAN mode.

In case of full manual landing, it was appropriate to deactivate the CWS mode at a minimum of 150 ft.

This does not mean that the pilots absolutely had to deactivate the CWS mode at this altitude. This means that if the pilot wanted to proceed to a full manual landing, he was recommended to deactivate the CWS at this altitude.

Once again, he could however remain in CWS mode and proceed to landing as such.

The technique of landing in CWS mode was simpler than landing manually.

During a full manual landing procedure, the pilot must begin to "flare" the aircraft at around 50 ft by slightly raising the nose of the aircraft to decrease the vertical speed as to remain within the limits of structural resistance of the landing gear and of the fuselage.

At this precise moment, the power of the engines must be reduced to "flight-idle"; the speed will normally decrease which will have for consequence to harden the downslope. The pilot will have to constantly adjust the nose of the plane with the

¹⁰⁶ According to Airbus philosophy, pilots can, on their own side and at the same time, act on the joystick, the resulting signal finally sent to the autopilot computers being the algebraic sum up of both signals. In case of dual and opposite inputs, the resulting signal will be zero and no signal would be sent to the computers, so the flight path will be not modified. In such conditions, giving the information of a dual input becomes a tremendous safety issue.

¹⁰⁷ Except in the case of an automatic approach.

control column (making sure that it is slightly raised) as long as a contact with the ground will not have been established.

When using the CWS mode, the pilot will only have to initiate the "flare" procedure and take the appropriate attitude for the landing. This attitude will be then maintained by the CWS whatever the thrust and speed.

The conclusion is that the use of the CWS, the day of the accident, was strictly in accordance with the Martinair and KLM standard operational procedures. The Experts will later analyze the disengagement of the CWS mode a few seconds before the accident itself.

8.6.3.2. THE HANDLING OF THE ENGINES

In the Portuguese report, there is virtually no question about the use of the engines because in some way, they are not involved in the accident.

But the Experts, taking into account some comments from the claimants, chose to develop this topic to avoid again any misunderstanding or inappropriate consideration.

The main parameter used to manage these engines was the low-pressure stage rotation speed, also called N1.

When at idle during a flight, the N1 was around 40%.

At full thrust, it was customary to have an N1 at around 105% with a maximum speed limit at 118,5% for the CF6-50C; the used value would basically depend on the conditions of the day.

These engines had great momentum inertia due to their mass but also due to their quite high rotation speed. As a consequence, the pilot will have to act with a significant anticipation to obtain the required thrust.

The certification rules have taken into account this characteristic when they defined the response time that had to be respected by an engine in order to get certified.

Here are the applicable rules issued by the FAA:

FAR § 33.73 Power or thrust response.

The design and construction of the engine must enable an increase—

(a) From minimum to rated takeoff power or thrust with the maximum bleed air and power extraction to be permitted in an aircraft, without over temperature, surge, stall, or other detrimental factors occurring to the engine whenever the power control lever is moved from the minimum to the maximum position in not more than 1 second, except

that the Administrator may allow additional time increments for different regimes of control operation requiring control scheduling; and

(b) From the fixed minimum flight idle power lever position when provided, or if not provided, from not more than 15 percent of the rated takeoff power or thrust available to 95 percent rated takeoff power or thrust in not over 5 seconds. The 5-second power or thrust response must occur from a stabilized static condition using only the bleed air and accessories loads necessary to run the engine. This takeoff rating is specified by the applicant and need not include thrust augmentation.

This is why the manufacturers set a minimum as to the idle value possible during the flight that they called "flight-idle".

It allowed to go from flight-idle to full thrust in less than 5 seconds, which was enough to avoid a speed decrease when the pilots would have to initiate a go-around maneuver,

Just to know, the value of ground-idle was around 25-30%, and the value of flight-idle around 40-45% depending on the outside temperature and on the indicated airspeed.

The engines automatically switch from flight-idle to ground-idle through a groundflight signal transmitted by a sensor located — depending on the aircraft — in the shock absorber of the nose gear when it is compressed, so when the aircraft is on the ground (as for the DC10 and many other aircrafts) or when a de-tilt of the wing gear at touchdown occurs (as for the B747).

An aborted landing.¹⁰⁸ is at all time possible even after the touchdown, but it must be performed before the thrust reversers are extended.

In order to avoid a thrust reversers jam, pilots are instructed not to attempt an aborted landing once the reversers are activated.

Here are the tables provided by General Electric (via Boeing) for the different values of N1 and N2 with reference to the outside temperature:

¹⁰⁸ Note the difference of wording: a missed approach procedure is initiated before the touchdown and an aborted landing is initiated after the touchdown but before the reversers extension.

ARAMETER IMITS	OAT	OAT	N2RPM +1.3%	N1RPM (MAX)	OAT	OAT	N2RPM +1.3%	N1RPM (MAX)
ITS	۰F	°C	-1.2% %N2	%N1	٩F	°C	-1.2% %N2	%N1
	-40	-40	57.8	24.1	+ 43	6	63.4	26.1
	-58	-39	57.9	24.1	45	(65.5	26.2
	-56	-58	58.0	24.1	46	8	65.6	26.2
	-50	-5/	50.2	24.2	40	10	03.1 47 0	20.3
	-33	-30	58.5	24.5	52	11	63.0	20.5
	-27	-33	58.6	24.4	54	12	64 0	26.4
	-26	-32	58.8	24.4	27	13	64.2	26.4
	-24	-31	58.9	24.5	57	14	64.3	26.5
	-22	-30	59.0	24.5	37	15	64.4	26.5
	-20	-29	59.2	24.6	61	16	64.5	26.6
	-18	-28	59.3	24.6	63	17	64.6	26.6
	-17	-27	59.4	24.7	64	18	64.7	26.6
	-15	-26	59.5	24.7	66	19	64.9	26.7
	-11	-24	59.8	24.8	68	20	65.0	26.7
	- 9	-23	59.9	24.9	70	21	65.1	26.8
	- 8	-22	60.0	24.9	72	22	65.2	26.8
	- 6	-21	60.2	24.9	73	23	65.3	26.9
	- 4	-20	60.3	25.0	(5	24	65.4	26.9
	- 2	-19	60.4	25.0	(9	26	65.6	27.0
	. 1	-18	60.5	25.1	81	21	62.8	27.0
	+ I	-17	40.0	25.1	02 9/	20	44 0	27.1
	7	-16	61 0	25.2	86	30	66.0	27 1
	0	-13	61.1	25.3	88	31	66.2	27.2
	10	-12	61.2	25.3	90	32	66.3	27.2
	12	-11	61.4	25.4	92	33	66.4	27.3
	14	-10	61.5	25.4	93	34	66.5	27.3
	16	- 9	61.6	25.5	97	36	66.7	27.4
	18	- 8	61.7	25.5	99	37	66.9	27.4
	19	- 7	61.9	25.6	100	38	67.0	27.5
	21	- 6	62.0	25.7	102	39	67.1	27.5
	25	- 4	62.2	25.7	104	40	67.2	27.6
	27	- 3	62.3	25.7	106	41	67.3	27.6
	28	- 2	62.4	25.8	108	42	67.4	21.6
		- 1	62.6	25.8	109	43	61.5	21.1
	32	0	62.7	25.9	111	44	61.6	21.1
	54	+ 1	62.8	25.9	117	40	67.8	27.0
	30	2	63.0	26.0	112	4/	68 0	27.8
	30	6	63 1	26 1	120	40	68.2	27 0
	39	4	105.1	20.1	120	47	00.2	21.7

ARAMETER	OAT	OAT	N2RPM	N1RPM	OAT	OAT	N2RPM	N1RPM	
IMITS	or		±0./%	±1.6%	о г		±0./%	±1.6%	
N115	4	-0	%N2	20N I	-1-	-0	3N2	4N 1	
	-40	-40	71.2	37.9	+ 43	+ 6	77.3	41.6	
	-38	-39	71.3	38.0	45	7	77.5	41.7	
	-36	-38	71.4	38.1	46	8	77.6	41.8	
	-35	-3/	11.6	38.2	48	9	11.8	41.8	
	-33	-30	72 0	38.5	50	10	78 1	41.9	
	-27	-33	72.1	38.6	54	12	70.7	42.0	
	-26	-32	72.2	38.6	55	13	78.4	42.1	
	-24	-31	72.4	38.7	57	14	78.5	42.2	
	-22	-30	72.5	38.8	59	15	78.6	42.2	
	-20	-29	72.7	38.9	61	16	78.8	42.3	
	-18	-28	72.8	39.0	65	1/	70.1	42.4	
	-1/	-21	73 1	39.1	64	18	79.1	42.4	
	-11	-24	73.3	39.3	68	20	79.3	42.6	
	- 9	-23	73.5	39.4	70	21	79.5	42.6	
	- 8	-22	73.6	39.5	72	22	79.6	42.7	
	- 6	-21	73.7	39.6	73	23	79.8	42.8	
	- 4	-20	73.9	39.7	75	24	79.9	42.9	
	- 2	-19	74.0	39.7	79	26	80.2	43.0	
	0	-18	74.1	39.8	81	27	80.5	45.0	
	+	-16	76 6	40 0	84	20	80.4	43.1	
	7	-14	74.7	40.1	86	30	80.7	43.3	
	9	-13	74.8	40.2	88	31	80.8	43.3	
	10	-12	74.9	40.3	90	32	81.0	43.4	
	12	-11	75.1	40.4	91	33	81.1	43.4	
	14	-10	75.2	40.5	93	34	81.2	43.5	
	16	- 9	75.3	40.5	9/	36	81.5	43.6	
	10	- 6	75.4	40.0	100	30	81.9	43.1	
	21	- 6	75.7	40.8	102	39	81.9	43.8	
	25	- 4	76.0	41.0	104	40	82.0	43.9	
	27	- 3	76.1	41.0	106	41	82.2	44.0	
	28	- 2	76.3	41.1	108	42	82.3	44.0	
	30	- 1	76.4	41.1	109	43	82.5	44.1	
	32	0	16.5	41.2	111	44	82.6	44.2	
	54	+1	76.0	41.5	115	46	82.9	44.5	
	30	3	76.9	41.5	118	47	83.1	44.4	
	70	,	77 0	14 6	100	40	07.7	11.2	

The Experts' conclusions are:

- during the approach and even just before the accident itself, the engines were correctly running without any defect or failure;
- At all time, including just before the accident, the engines were able to provide the pilots with all the required thrust even in case of missed approach procedure or aborted landing procedure.

8.6.3.3. THE HANDLING OF THE AIRSPEED

The thrust could be adjusted manually or automatically through two auto throttle systems called "Auto-Throttle – Speed Computers" (AT/SC) or shortly "ATS".

The standard procedure was to use the two systems for the whole phases of the flight, even when flying the plane manually.

This policy was implemented because of the high reliability of the systems, providing an excellent protection against uncontrolled decreases in speed whatsoever during takeoff, approach and, with some limitations, in turbulent atmosphere with risk of windshear.

The DC10 was equipped with two of these systems which enabled:

- a more accurate follow-up depending on the situation, the intended speed of the pilot, or the position of the throttle (either for take-off or aborted landing).
- At all times maintaining the well-functioning of the engines within the limits set by the manufacturer.

Two full different channels provide three functions:

- automatic control of the thrust delivered by the engines via a Thrust Rate Computer (TRC) and respective Fuel Control Unit (FCU);
- management and control of the speed;
- protection against stall.

Each computer provides the following outputs:

- management of the thrust levers;
- fast/slow indicator on each main instrument (Attitude Director Indicator or ADI) and respective appropriate failure signal;
- information to the Flight Director (FD) horizontal command bar when on Take-Off or Go-Around (TO/GA) modes;
- Stall warning;
- management of the automatic extension of slats (protection against stall).

For the TO/GA modes and for the stall warning, the <u>computers</u> use specific sensors providing the Angle of Attack or AOA.

For the other functions, the computers use signals provided by various components among them the Air Data Computers or ADC (providing the calibrated airspeed, altitude and vertical speed).

Each ATS computer provides information to an electrical motor driving the thrust levers via clutches.

The pilot can manually override these clutches at any time but it will require higher force than usual. If the pilot acts on the levers while the ATS are engaged, as soon

as the pilot stops his actions, the levers will return to the automatic computed position.

In regular conditions, one would pilot the DC10 with the two ATS systems always activated during the flight.

The use of these systems allowed, in case of go-around, to go at full-throttle immediately (less than 5 seconds), just by depressing a push-button located at the front of the engine thrust levers.¹⁰⁹.

The Experts have analyzed the choice of the approach speed and the management of this speed.

8.6.3.4. THE LANDING GEAR BRAKING SYSTEM

The DC10 was equipped with a very efficient breaking system that used disks on all wheels of the main landing gears (central and wings).

As it has been the case on all aircrafts for decades, the main gear wheels are protected by an anti-skid system not to get stuck; a similar system to the one we see nowadays on cars.

This system allowed to optimize breaking while keeping the wheels in rotation as to always obtain maximum deceleration.

However, it was obviously mandatory not to land with the wheels locked by an unwanted pilot's action on the brake pedals. This protection was the job of a subsystem of the anti-skid system called the "free wheel" protection ¹¹⁰.

This system prevented the hydraulic pressure to be released on the breaks as long as the conditions were not obtained, that is to say as long as the aft main wheels of the wing gears had not reached a certain rotation speed.

Clearly said, the pilot could land while applying maximum pressure on the pedals because the breaks would not have started functioning.

As soon as the aircraft would have touched the ground, and that the wheels would have started rotating at the proper speed, the anti-skid system would have authorized the hydraulic pressure to be released.

The anti-skid system ensured that the wheels would not get blocked by the breaking system because:

- to avoid aquaplaning in the eventuality that the runway was wet or "contaminated";
- to avoid blowing up the tires as it would make breaking absolutely impossible.

On the DC10, only the rear axletrees of the wing's landing gear were equipped with the "free-wheel" system because it was these wheels which physically.¹¹¹ touched the

¹⁰⁹ Under the condition that the flight directors and the AT-SC calculator are both activated.

¹¹⁰ Just to know, the reader will note that this system was constantly tested during maintenance flights that followed the technical inspection.

¹¹¹ Because of the attitude on the aircraft at this moment.

ground first during a landing, whereas the front and the central landing gears would touch the ground a little bit later.

Assuming that the wheels of the main landing gears were being blocked by the pilots, who pressed the breaking pedals while flying, is therefore impossible because of the way the anti-skid and free-wheel system was designed.

An important point that was not mentioned in the final Portuguese report is that the aircraft was, on the day of the accident, "fairly light", in the sense understood by crewmembers.

This means that the actual mass at landing was rather far away from the limits of the aircraft.

8.6.3.5. THE NAVIGATION CAPABILITY OF THE KSSU DC10

Another important point is the design itself of the KSSU DC10 in terms of navigation follow-up.

We must fully understand it as this fact could have represent a factor to the way the accident occurred, not technically speaking but because of the induced workload for the pilot flying.

Moreover, the Experts consider it as important to provide answers on this point because of the comments they read in the provided documents.

The KSSU DC10 was not designed to follow a magnetic radial, or in other words, an electromagnetic route.¹¹².

The consequence is that for a VOR/DME approach of the same kind that was used the day of the accident at Faro, the pilot of a KSSU DC10 cannot automatically follow the approach radial but can only follow the route defined by a specific heading, using the HEADING (HDG) mode of the flight director and the autopilot.

This does not mean that the flight path monitoring is not accurate, but it means the workload of the crew members will be greater on this aircraft than it would be on another type of aircraft.

The adjustments on HDG mode must constantly evolve depending on the variations of the wind, and therefore depending on the drift due to the wind.

Regarding the vertical path, the type of (non-precision) approach performed on the day of the accident does not provide a guidance signal for a descent slope that can

¹¹² The KSSU DC10 is designed to follow horizontal routes by relying on fictional references that are defined in three ways:

According to geographical coordinates (north/south and east/west);

According to electromagnetic radials emanating from at least two ground stations;

According to one radial emanating from one unique station and the distance to it.

The flight paths are then calculated in order to join these points one by one so that the autopilot might follow the resulting route if that is what is required by the pilot.

be automatically followed because there is no radio-magnetic navigation signal that would materialize this slope.

The pilot can only follow a descent slope by using one of the basic modes of the autopilot: the VERTICAL SPEED (VRT SPD) mode.

A third aspect to be analyzed here is the interaction between the aircraft's systems and the pilots.

Much information is being given to the pilots to help them, and assist them in their work. This is why we refer to these systems as "Flight Guidance."

Among these tips given to the pilots is the constant display of instantaneous 'actual' winds.

It is calculated:

- from aerodynamic data measured by "pitot tubes" type of sensors as well as Angle of Attack sensors (AOA sensors);
- and from data coming from the accelerometers, which compute the movements of the aircraft center of gravity.

It is then possible to calculate by mathematical comparison between these two types of data the actual wind on the aircraft's flight path.

The calculation can only be correct, whatever the sensors accuracy, if the calculation hypotheses are valid.

Among the mandatory hypotheses, it is necessary that the aircraft flies on a perfect symmetrical configuration.

In case of slide slip approach configuration, the aerodynamic data measured are wrong, and so is the result.

At the very end of the approach.¹¹³, or just before the touchdown, pilots will need to compensate a cross wind by aligning the aircraft axis with the runway center line, then creating a slide slip angle.

Without judging of what happened on board of the aircraft at the very end of the final approach on the day of the accident, all experts come to the agreement that the pilots performed a certain set of maneuvers — especially on the rudder — that were ultimately decisive.

As soon as such maneuvers are being performed, the indications given on the wind measures become false; and these maneuvers started rather soon, at 400 feet, if we refer to the flight recordings.

¹¹³ During automatic approaches using autopilots, the system is designed to begin the decrab maneuver at 138 ft above the ground. Before this point, the wind calculated by the computer is right. When flying the aircraft manually, the align procedure is normally initiated by the pilot between 100 and 50 feet.

8.6.4. THE FLIGHT

8.6.4.1. THE FLIGHT PREPARATION

8.6.4.1.1. THE WEATHER FORECAST

The official report states that the crew visited the weather forecast center prior to departure.

However, this is not clear since passing by the weather forecast center prior to the flight is normally not mandatory, according to the Martinair procedures.

It is of course required to gather weather forecast information for the departure, the route itself, the destination airport, as well as potential emergency airports. This is clearly stated in the Flight Crew Operating Manual of Martinair.

The information available on this particular day — given in the form of a Meteorological Aerodrome Report (METAR) — indicated the actual conditions for a specific hour, as well as the possible evolution of the weather for the two following hours or for a specified time period.

The weather forecast is transmitted in the form of a Terminal Aerodrome Forecast (TAF); this information comprises the forecast for an indicated time period of 6, 9, or 12 hours.

On this specific day, the pilots had a METAR that dated from the December 21st at 4:00 UTC.¹¹⁴

•	Wind:	140°/13 kt
•	Visibility:	more than 10 km
•	Clouds:	2/8 stratocumulus at 2000 ft
		3/8 Altocumulus at 10000 ft
		1/8 cumulonimbus at 2500 ft
•	Temperature:	15°C
•	Dew point:	14°C
•	QNH:	1014 hPa

The wind was far from posing any challenge regarding the aircraft limitations on a wet runway.

At the moment of the accident, "octa" was in use as the value that indicate clouds, 8/8 meant that the sky was completely covered and the value indicated the height of the clouds' base.

The gap between the temperature and the dew point let one assume that humidity was high, ranging probably between 90 to 95%.

¹¹⁴ RvO chapter 1.7.7.2.1 – page 35 of the non-official translation of the RvO

Finally, the atmospheric pressure did not reflect the reality of a depression since it was even higher than the standard pressure of 1013,25 hPa.

This information at hand allowed to predict a final approach that would be a little bumpy because of the presence of 'instability' clouds, but without major issue below 2000 ft.

Simultaneously, the TAF of December 21st from 4:00 UTC to 13:00 UTC indicated the following:

- Wind: 150°/15 kt
- Visibility: more than 10 km
- Clouds: 3/8 stratus at 500 ft 4/8 Cumulus at 1200 ft 5/8 stratocumulus at 2000 ft
- Tempo Visibility: 8000 m Showers 5/8 Stratus at 400 ft 5/8 Cumulus at 1200 ft
 Inter Visibility more than 10 km Moderate thunderstorms 2/8 cumulonimbus at 1800 ft

The wind remained in acceptable range, even on a runway that would be wet. The lowest base of the could cover was below 3/8 and could therefore be ignored. Visibility never went below the minimum value. Stormy showers were to be expected.

For a pilot, such situations are not unusual and are in no case difficult to handle; the atmosphere is bumpy, and moderate rain can occur, which would call for the use of windshield's wipers in fast mode – but nothing more.

8.6.4.1.2. THE TECHNICAL STATUS OF THE AIRCRAFT

An important detail to be considered to better understand how the pilots perceived the situation is the mechanical aspect of the thrust reverser of engine N°2.

Landing on a contaminated runway.¹¹⁵ was advised against.¹¹⁶ if one deceleration system was not operational.

¹¹⁵ JAR-OPS 1.480 – Terminology : **Contaminated runway**. A runway is considered to be contaminated when more than 25% of the runway surface area (whether in isolated areas or not) within the required length and width being used is covered by the following :

If the captain was warned before landing that the runway was or could get contaminated, he could have simply not even take-off with a thrust reverser that was not operational (because he would have needed all thrust reversers to be fully operational).

However, he took the <u>rational</u> decision to depart despite the fact that the thrust reverser N°2 was not operational, which did not jeopardize the safety of the flight at this stage.

The aircraft departed, it seems, with a 40 minutes delay; which was the time needed by the maintenance team to stow the thrust reverser N°2.

The engine N°2 is located right above the fuselage and at the bottom of the vertical fin, which makes its access rather difficult.

In these conditions, the operators asked their crews to avoid using the thrust reverser N°2, except in case of emergency.

This instruction was to avoid the thrust reverser to get potentially stuck in "not retracted" position, which would have involved a heavy intervention during the stopover.

However, operators asked their pilots to systematically use the thrust reverser $N^{\circ}2$ during return flights at main base, simply to verify the well-functioning of the reverser.

During the flight prior to our case, a problem with this reverser occurred that required an intervention from maintenance.

There are two possible options at this stage:

- Solve the problem by repairing the defect before the next flight;
- Depart with the thrust reverser stowed in position "retracted" because based on the forecast its use was not required.

Aircraft manufacturers have therefore developed a policy allowing to take off with a faulty system, in order to reach an airport where troubleshooting was possible. It therefore becomes possible to fly for a specified time even with a failure or a defect since the flight safety is protected.

However, some systems are essential and takeoff is not allowed if they are not operational: these cases are called « NOGO ».

Manufacturers issue tables of defects with the acceptable duration of the defect and the procedures to implement either by the flight crew or by maintenance.

⁽i) Surface water more than 3 mm (0.125 in) deep, or by slush, or loose snow, equivalent to more than 3 mm (0.125 inches) of water ;

⁽ii) Snow which has been compressed into a solid mass which resists further compression and will hold together or break into lumps if picked up (compacted snow); or

⁽iii) Ice, including wet ice.

¹¹⁶ But not forbidden

These tables are called "minimum equipment lists" or "MEL", and they are certified as crucial elements of the whole aircraft certification.

Only the captains are allowed to use these MEL; first, because they are the only ones responsible for the flight and, second, they are the only ones able to assess the impact of any failure regarding the operational environmental conditions, or regarding other potential issues.

Here is the issued table¹¹⁷ for the reversers:

★ - Thrust Reversers	One fan thrust reverser may be unserviceable provided:				
	. Aircraft shall not depart a station where repair or replacement can be made.				
	 The unserviceable fan thrust reverser is secured and stowed according to MAI 78-00-01. When dispatching from a wet or contaminated runway, the thrust used for take-off shall not be less than full A rating. Asymmetric thrust reverser configuration does not seriously affect directional control due to the runway conditions at destination and/or alternate airports. Anti-skid system is in Phase IV configuration. 				

The star¹¹⁸ at the beginning of this text means that this item is a "consult" item. The dispatch depends then on the evaluation of the situation and regarding the operational context on the captain's decision.

Departure seems to be impossible from Amsterdam because this airport is the Martinair's main base.

But the text does not say that.

It is stated "from an airport where repair or replacement can be made." The questions are:

- Is it possible, that day, to perform the repair in Amsterdam?
- Is the spare part immediately available or should Martinair's maintenance ask a supplier to send this part?

The answer is not so obvious.

Martinair, as subsidiary of KLM, must comply with the commercial agreement of its mother company. And the maintenance is managed by an agreement being part of the KSSU Consortium which is in charge with all maintenance topics.

The engines and all its systems (including reversers) are managed by a company based in Paris — REVIMA — itself being a subsidiary of UTA French Airlines.¹¹⁹, member of the KSSU consortium.

¹¹⁷ Refer to KLM Aircraft Operations Manual § 3.1 Dispatch Deficiency Guide – 3.1.7 Power plant

¹¹⁸ Refer to KLM Aircraft Operations Manual § 3.1 Dispatch Deficiency Guide – 3.1.0 General - 0.2 Categories

That means that the spare part could not immediately be available in Amsterdam and had to be moved from Paris, allowing the Captain to consider that the repair cannot be made in Amsterdam.

In any event, the meteorological information provided to the flight crew before departure did not make the well-functioning of the three thrust reversers mandatory.

When in flight, it is not allowed to use the MEL in case of failure or defect. The flight crew must use the appropriate 'abnormal' or emergency check-lists

Finally, if the captain made the decision to take-off, it means that he did not plan the fact that the runway might be contaminated at arrival.

If conditions at arrival are difficult, the crew is trained to handle it and mitigate risks; for instance, the crew may request more fuel before departure to wait for the conditions to improve at arrival, or divert to an alternate airport.

8.6.4.2. DURING THE FLIGHT

The situation is different.

The captain handles the situation as it comes and nothing forbids him to continue the flight with a thrust reverser that is not operational.¹²⁰, except if the procedure or a checklist indicates otherwise, which was not the case.

Moreover, the reversers are not taken into account for the landing performances assessment.

An operator has no possibility whatsoever to impose anything to one of its captains once the flight has started; however, it needs to be noted that the operators advise strongly against landing when the runway is flooded or contaminated at the same time as one of the systems that contribute to deceleration is not fully working.

It is clearly up to the Captain to evaluate the situation and make the decision that he sees to be adequate.

8.6.4.2.1. THE WEATHER SITUATION AT ARRIVAL

It was not obviously easy to manage.

The analysis of the overall weather situation is useless in the context of the mission given to the Experts.

¹¹⁹ This airline is a member of the Air France consortium since January 26th, 1990; and the former agreements were still applicable, including the repartition inside the KSSU consortium. In this context, all issues regarding the engines and the landing gears are under the UTA's responsibilities.

¹²⁰ And in flight, except in case of abnormal extension of the reverser, it is not possible to know if whether or not the reverser will be operational during the landing !

At maximum, one may consider that a rather active depression, associated with an important humidity level, generated a strong instability that has a considerable vertical influence in the area of Algarve.

The presence of unstable clouds— "cumulonimbus"—all around Faro was confirmed. Stormy cells were also reported in the immediate surroundings of the airport, especially in the south, south-west and south-east of the platform at pretty close distance.

Pilots signaled several storms less than 10 nautical miles out of runway 11, and one very close to the axis of approach.

According to official reports, shower's measurements recorded between 07:27 UTC and 07:37 UTC reach the value of 60 to 65 millimeters of water per hour.

According to meteorology criterion, such a quantity is considered as exceptional. It represents 1 liter of water by m^2 per minute.

Such quantities of water correspond — according to standards classification — to an exceptionally strong storm, and therefore to the presence of storm cells that, first, have a great potential for evolving, and second, that also have a powerful vertical influence.

There are three important consequences to such a situation:

- It can strongly disturb the adherence of the lateral trajectories as the pilots avoid active/shaky zones;
- It can induce vertical disturbances with the appearance of downbursts or ascending wind bursts, even more violent and unpredictable when the cells are highly active;
- It might under certain conditions generate windshear, and even microbursts.¹²¹, which are considered as an important danger in aeronautic.

The Portuguese weather forecast services predicted the presence of storms and rain that could be strong, however, it was impossible to predict the following:

- The localization of stormy cells with a small diameter on a macroscopic scale;
- The maps called TEMSI or SIGWX cannot indicate these isolated cells whose evolution cannot be accurately located and that often move pretty fast;
- They limit themselves to merely indicate the likelihood of stormy zones in given geographical areas;
- the localization of vertical phenomenon such as windshears or downbursts.

The Official Report states the following in its pages 15 and 16 of the non-official translation:

« According to the crew statements:

¹²¹ The dangers of the windshears, downburst and microburst have been investigated since

During descent and approach, the Captain detects on the weather radar, several returns.¹²², corresponding to rain showers located West and South of field. This last one at a distance of more than 50 miles.

During the outbound leg of the procedure, he detected a CB, west of the field between 7 and 12 DME.

During descent, the F/E noticed a return south of Faro at an estimated distance of 10 miles. The crew realizes from the communication between Faro Approach and the flight TP120 that ... what they identified as rain showers was a thunderstorm cloud.

By the time when turning final about 8 miles DME, turbulence of a degree superior to moderate could have been found and if so, it would be related to the returns detected in the weather radar, west of the field.

During final approach, light to moderate turbulence was encountered.

The aircraft was flying in and out of clouds and the forward visibility was not good. Continuous rain was experienced in some occasions, namely near the threshold, where due to the rain, the visibility was very poor. Nevertheless, immediately before the threshold, visibility was good."

All together, these statements are coherent with the situation as reported by METARs, and there is no reason not to accept these statements as proof that the approach was rather shaky and that following the trajectories as indicated on the maps must have been difficult.

According to the Jeppesen VOR/DME approach chart.¹²³, the place to begin the final turn was at 8 nautical miles (Faro DME) and to begin the final descent at 7 nautical miles (Faro DME).

Active thunderstorm center of activity, between 7 and 12 nautical miles west of the airport, were attested by the F/E indicating a strong reaction of the autopilot to maintain altitude.¹²⁴

According to the procedure, the height of the last level before final descent was set at 2000 ft QNH with the start of the final descent set at 7 NM DME.

Turning at 8 NM DME allows then to avoid the stormy zone while respecting, first, the trajectory as defined by the approach map, and second, the descent point as established by the procedure.

¹²² Technically speaking, we can also use the words « echoes »

¹²³ Refer to annex 8.6.4.5.1

¹²⁴ Lijst 4 Map-1-sur-4 – F/E statement made the 2nd of February 1993

Experts also consider that the choice by the pilot flying to stabilize the flight path for a few seconds to heading 080°.¹²⁵ was an excellent decision, allowing both a clear final approach path interception without going above the final descent path.

The only critique we could make towards the crew is not to have sufficiently anticipated the beginning of interception because of an unfavorable wind that pushed the aircraft outside of the planned trajectory.

Moreover, the turn toward the final approach radial was performed with only a 25° bank angle because it was performed through the autopilot, which induced a slight overshoot from the approach axis that should have been adjusted immediately.

8.6.4.2.2. THE CHOICE OF THE APPROACH SPEED

On the day of the accident, the landing weight of the aircraft was around 161/162 tons.

According to this weight, the correct reference speed (REF) should be set at 139 knots without wind corrections.

The FCOM indicates that the command air speed bug is set as required, according to the actual configuration and, if applicable, the wind correction factor.

To compensate the effect of the wind gradient near the ground 126 , this speed has to be amended as indicated by FCOM § 3.3.5 « Approach and landing » - 03 - Wind correction factor (WCF).

The amended approach speed should have been set at the maximum of the following ¹²⁷:

Wind	Autoland	Manual landing ATS ON			Manual landing ATS OFF		
			Min	Max		Min	Max
Steady state	5 kt	¹ / ₂ of the wind above 20 kt	5 kt	20 kt	1/2 of the wind above 20 kt	5 kt	20 kt
Gust	5 kt	All of the gust above 5 kt	0 kt	15 kt	All of the gust	0 kt	20 kt

Regarding the to-day conditions:

- The wind issued by ATC was: 150° at 15 kt maximum 20 kt;
- the Captain considered a gusting wind condition;
- According to the crew's statements, the gust, if applicable, will be considered as the difference between the maximum value of the wind and the average one. In our case, the gust is 5 knots.

Consequently, the landing bug (white bug) should have been set at 139 knots and the approach command speed bug (yellow bug) also at 139 knots.¹²⁸.

¹²⁵ providing an interception heading of the final flight path under 30° which is the recommended value.

¹²⁶ This phenomenon is called the boundary layer effect.

¹²⁷ KLM FCOM § 3.3.5 – 03 – Approach and landing - Wind correction factor.

8.6.4.3. WINDSHEAR OR NOT WINDSHEAR

8.6.4.3.1. FIRST, WHAT IS A WINDSHEAR?

The FAA definition tells us that a windshear is a change in wind speed and/or direction over a short distance. It can occur either horizontally or vertically and is most often associated with strong temperature inversions or density gradients. Windshear can occur at high or low altitude.

Airbus, in a document issued in 2007, gives us another definition for the windshear:

Windshear is defined as a sudden change of wind velocity and/or direction. Windshear occurs in all directions, but for convenience, it is measured along vertical and horizontal axis, thus becoming vertical and horizontal windshear: Vertical windshear:

- Variations of the horizontal wind component along the vertical axis, resulting in turbulence that may affect the aircraft airspeed when climbing or descending through the windshear layer
- Variations of the wind component of 20 kt per 1000 ft to 30 kt per 1000 ft are typical values, but a vertical windshear may reach up to 10 kt per 100 ft.

Horizontal windshear:

- Variations of the wind component along the horizontal axis (e.g., decreasing headwind or increasing tailwind, or a shift from a headwind to a tailwind)
- Variations of wind component may reach up to 100 kt per nautical mile.

Wind shear conditions usually are associated with the following weather situations:

- Jet streams
- o Mountain waves
- Frontal surfaces
- Thunderstorms and convective clouds
- o Microbursts.

Neither the FAA nor Airbus give us any precise value to define the beginning of a windshear.

If we cannot use a threshold value to know if, whether or not, windshear occurred during this approach, we might use the evolution of the flight path, taking into account the pilots' actions.

Still according to Airbus, here is how it is possible for a pilot to recognize the presence of windshear:

¹²⁸ The yellow bug will be the reference for AT/SC computer.

Timely recognition of a windshear condition is vital for the successful implementation of the windshear recovery/escape procedure.

The following deviations should be considered as indications of a possible windshear condition:

Indicated airspeed variations in excess of 15 kt; Ground speed variations;

Analog wind indication variations: Direction and velocity;

Vertical speed excursions of 500 ft/mn;

Pitch attitude excursions of 5 degrees;

Glide slope deviation of 1 dot;

Heading variations of 10 degrees;

Unusual autothrust activity or throttle levers position.

What are the various configurations and the interferences with the aircraft flight path?

Windshear in front of the aircraft:

The aircraft speed increases significantly

The crews do not always perceive this increase of the headwind as a risk.

But such a headwind gust de-stabilizes the approach of the aircraft, which will tend to fly above path and/or accelerate, if the pilot does not react adequately.

If the headwind shear occurs at takeoff, the resulting aircraft performance will increase. Once out of the shear, the indicated airspeed decreases thus leading to an AOA increase which might trigger the alpha-floor protection and/or stick shaker activation.

The aircraft crosses the windshear area:

Vertical downinterims are usually preceded by an increase of the headwind component. If the pilot does not fully appreciate the situation, he/she will react to the headwind gust effects to regain the intended path by reducing the power and by pushing on the stick. At that point, a vertical downinterim will increase the aircraft sink rate, which will bring the aircraft below the intended path.

Windshear behind the aircraft:

In case of a sudden increase of the tailwind, the aircraft airspeed decreases instantaneously. The lift decreases and the aircraft tends to fly below the intended approach path.

If the pilots pulls on the stick to recapture the path without adding sufficient thrust, the AOA will increase significantly and the aircraft will sink down.

If sufficient thrust is set to regain the intended path, but the pilot's reaction is then slow to reduce the thrust once back on the path, the aircraft will fly above the path and/or will accelerate.

All combinations between these three scenarios are possible, with various intensities, and depending on where windshears appear.

8.6.4.3.2. THE NLR ANALYSIS AND ASSOCIATED DOCUMENT

In the documents sent by the Court, two reports are issued under the NLR responsibility:

- The first one the 13/02/1993 named "Windshear analysis using flight data from the DC10 crash at Faro airport" (NLR CR93080C);
- The second one the 20/06/1994 named "Analysis of additional flight data of the DC10 accident at Faro Airport" (NLR CR94238C);¹²⁹

According to the "Summary of the additional NLR windshear study"¹³⁰ by M. H. Tigchelaar, Senior engineering test pilot RLD (Airworthiness department), for the first report, "certain data were not available to NLR".

In the second report, "Additional data was requested and received from MDC and part of the analysis was recalculated".

In this document, the two analyses performed by the NLR are merged and the main conclusions are:

- The change-over from CMD to CWS later than indicated in the first report;
- The data shows that the instability begins before the disengagement of the autopilot (VRT SPD mode);
- The functioning of ATS was normal. The pilot probably overrides the throttles to close them even if this reduction was possibly initiated by the ATS;
- The wind at touchdown was beyond the aircraft limits;
- The reversion from CWS to MAN is a contributing factor to the heavy touchdown;
- The reversion was caused by an opposite action¹³¹ of the two pilots;
- The slide slip calculations are confirmed. That means that the calculations about wind, windshear, downbursts and turbulence was good;
- The instability was not induced by the pilot (not a Pilot Induced Oscillation).

Other considerations are issued:

- Difference between landing technics with or without use of CWS;
- Incidents involving the use of CWS and/or AT/SC;
- The possible consequence of aircraft instability on the pilots' decision de reduce the thrust;
- The CWS can stabilize the aircraft "when no stick force inputs are make on the control column";
- The combination CWS/ATS may "have contributed to the observed longitudinal instability".

Based on the NLR's analysis, the conclusion of this document is that the collapse of the gear is due to two reasons:

- A vertical speed out of the limits because of thrust reduction itself induced by longitudinal instability;
- A crosswind stronger than the aircraft limits, whose crew was unaware.

¹²⁹ RvO – Annex 4

¹³⁰ document provided in the Lijst 4 Map 4-sur-4, sent to the Experts by the Court at the beginning of January 2016

¹³¹ This means a rapid action to the left followed by a rapid action to the right.

The conclusions of the document NLR CR93080C and confirmed by the document NLR CR94238C, both documents issued by the NLR under contracts established with the Dutch Aviation Safety Board, are:

- The weather was turbulent because of crosswind hence with turbulence, gust
- The aircraft crossed a first downburst area from which the flight emerged at about 700 ft;
- The aircraft then crossed two other microbursts, qualified as "small" beginning at about 1 nautical mile from the threshold;
- "The last microburst caused headwind-tailwind changes of a magnitude that could have triggered a windshear alert...";

These conclusions indicate that the situation occurred "close to the ground, at an altitude of about 50 meters."

But at the same time, the NLR moderates these conclusions, indicating that "because of the rapidly varying wind it is sometime hard to differentiate between windshear and turbulence."

Despite these comments, the NLR indicates that the landing took place with winds near or exceeding the crosswind limits of the aircraft.

The NLR gives a value of 40 knots crosswind from the right when overhead the threshold and of about 70 knots 10 seconds before touchdown.

The NLR conclusions about the reduction of thrust is that the best assumption is that the pilots have initiate it, considering that the AT/SC was operating normally.



One of the most obvious reasons for the NLR to conclude to the presence of three windshear situations is the change in ground speed as indicated in the diagram above¹³².

8.6.4.3.3. THE EXPERT'S OPINION

Given the meteorological condition around Faro's airport on the day of the accident, that constituted a hostile environment with active stormy cells, the probability to come across vertical winds going up or down was high.

At this time, systems on board were not very useful to detect vertical winds or anticipate horizontal variations.

Generally speaking, the potential for anticipation was very low; and even though there has been progress, it is still true today.

¹³² Document NLR C93080C page 53

Preventing from the effects of windshear relied therefore solely on the observation that could be made of different parameters during the flight.

And in this context, the pilots had a strong advantage on the readings of 'immediate' actual wind computed by the RNAV system and that would give them some useful information, even though it would always be delayed.

The automatic system responsible for maintaining speed was also quite helpful to handle quick variations of the indicated speed.

Finally, airport operators set up ground systems around the airport that enabled the measuring of the wind to detect potential windshear; these ground systems were set up to mitigate the risks associated with brutal wind variations.

Such systems have been designed and used for quite a while already due to fatal accidents occurring especially in the United States.

At the moment of the accident, the airport of Faro was equipped with a system that would record meteorological data, analyze these information, and finally broadcast it; however, it was not equipped with a global system of alert since the local and usual meteorological conditions did not require it.

The system called "Sistema Integrado de Observâo Meteorologica" or SIO, is precisely described in the paragraph 1.7.4.3 of the official Portuguese report:

- A central station that gathers and analyze information coming from sensors spread throughout the aerodrome's perimeter, close to the runway thresholds 11 and 29.
- Data are recorded every 30 seconds and displayed on a special screen meant to do just that; the screen is located in the airport control tower.
- Precisely 10 minutes following each hour, a report is printed and displayed in second page of this special screen.
- The system's time reference is independent and must be adjusted by the controllers.
- The controller may display for one or the other runway threshold (11 or 29), an instantaneous wind, or a wind with an average of 2 or 10 minutes.
- The wind data (average wind of the last 5 seconds) is displayed every second on the special screen in the control tower.
- The system has the capacity to generate windshear alert if the vectorial difference between the wind values measured at threshold 11 and 29 are over 15 knots.

The commission of investigation highlights the weaknesses of the system in its report; especially the fact that the recordings only show the average of the two last minutes and that this value is not the vectorial value but a mere arithmetic average.

The recordings presented on page 46 of the official report indicate a strong rotation of the wind as well as an increase of its velocity at the time of the accident (07:33:00 - SIO reference).
	Average v	vind (2 mir	iutes)				
SIO Time	Runway 1	1		Runway 29			
	Direction	Intensity	Gust		Direction	Intensity	Gust
07 :30 : 30	140	20	26		150	19	25
07 :30 :30	140	21	26		150	19	25
07 :31 :00	140	20	26		150	18	25
07 :31 :30	160	21	35		160	18	25
07 :32 :00	180	22	35		170	20	25
07 :32 :30	190	24	35		180	22	29
07 :33 :00	190	27	35		200	24	32
07 :33 :30	180	26	35		200	27	34
07 :34 :00	170	25	35		200	29	34

The data, by themselves, allow for only one thing: to notice that a rotation of the wind occurred, combined with a significant increase of intensity.

However, this is a situation that is usual and systematic when a storm is close to an airport.

According to this records, the wind changes from 140° to 190° (with a runway oriented at 106°) between 07:31:00 and 07:33:00 SIO time.

So, at 07:31:30 SIO time, with a recorded wind coming from the 140° for 20 knots, we have an additional headwind component of about 17 knots with about 12kt crosswind.

With a wind at 190° for 27 knots, we have about 3 knots headwind and about 27 knots crosswind.

To this variation, we must add the brutal increase by 8 knots of the gust wind meaning a 35 knots crosswind under gust.

A slight variation of the direction of the crosswinds can represent a danger well known for the pilots because these variations can generate the wind to change from headwind to tailwind very rapidly.

These variations increase the risks of destabilization of the trajectory, which would call for action on the engine thrust to correct the speed, but also on the stick in order to adjust the flight path.

As long as the aircraft is under automatic control and it is not strongly destabilized neither for the speed nor for the attitude because the autopilot will maintain the pitch and roll and the ATS will maintain the speed.

But the flight path in itself, can be destabilized because, in our case, the flight path monitoring is not coupled with ground signals (localizer and/or glide slope) and the reaction of the autopilot can be slower than the human one.

After automatism disengagement, the corrections implemented by the pilot should be done more rapidly and with a greater efficiency.

The closer the aircraft gets to the ground, the more difficult it becomes to gauge the corrections needed; the pilot could easily over-correct by reflex.

Ultimately, the flight path's instability in itself is an objective and strong indicator for the presence of wind variations. And strong wind variations can become windshears.

That being said, any approach occurring under turbulent conditions with strong crosswinds that brutally vary in both direction and intensity can be destabilized—without the occurrence of windshears.

The Experts consider that the only thing that they can objectively deduce from this analysis is that the flight path was destabilized because of meteorological conditions, whatever their nature.

8.6.4.4. THE RUNWAY CONDITIONS AND THE ASSOCIATED PERFORMANCES AS EVALUATED BY THE CREWMEMBERS

8.6.4.4.1. COULD WE CONSIDER THE RUNWAY CONDITIONS AS A CAUSAL OR A CONTRIBUTING FACTOR TO THE ACCIDENT?

This is a quite important question.

The runway surface conditions are not, in this case, a cause or a contributing factor for this accident.

The accident occurred at the moment of the first contact with the ground, and not later on.

The runway surface condition — flooded, wet, short, long, etc. — had no impact on the accident whatsoever, and is therefore irrelevant.

8.6.4.4.2. WHAT ABOUT THE APPLICABLE RULES AT THE TIME OF THE ACCIDENT? (THE EUROPEAN JAR-OPS)

First of all, to discuss the expression "flooded", and how it has to be taken into consideration both in regards to crosswind limitations and to the decision to continue the approach made by the captain, we must refer to the rules in force at the time of accident.

For an European operator, the rules to follow were those of the JAR-OPS, as soon as they were adopted nationally.¹³³.

The Claimants' advisors team is right when he indicates that the final JAR-OPS was issued in May 1995.

At the time of accident, the applicable rules were the national rules.

 ¹³³ In reality, these rules were not made mandatory until they were adopted on a national scale. And JAR OPS
 1 was adopted the Netherlands at the time of the accident.

But to ensure a smooth harmonization between the national rules and the rules based on JAR OPS recommendations, all countries in Europe began to change their own regulations 4 or 5 years before the introduction date of 1995.

This is why the Experts use the JAR OPS as reference for their assessment although it was not the applicable reference.

Moreover, these considerations are of no consequence on this accident itself.

But the non-decision of go around had a consequence.

JAR-OPS 1.480 – Terminology

(2) Contaminated runway.

A runway is considered to be contaminated when more than 25% of the runway surface area (whether in isolated areas or not) within the required length and width being used is covered by the following:

- (i) Surface water more than 3 mm (0.125 in) deep, or by slush, or loose snow, equivalent to more than 3 mm (0.125 in) of water;
- (ii) Snow which has been compressed into a solid mass which resists further compression and will hold together or break into lumps if picked up (compacted snow); or
- (iii) Ice, including wet ice.

(10) Wet runway.

A runway is considered wet when the runway surface is covered with water, or equivalent, less than specified in subparagraph (a)(2) above or when there is sufficient moisture on the runway surface to cause it to appear reflective, but without significant areas of standing water.

The JAR's did not encompass the notion of "flooded runway", but simply of "contaminated runway".

Before figuring out how the captain interpreted this term, and if we assume that the expression "flooded" was used in the sense of "contaminated", then the question we ought to ask is how did airport services determine that the runway could be "contaminated"?

JAR-OPS 1.485 – General

- (a) An operator shall ensure that, for determining compliance with the requirements of this Subpart, the approved performance data in the Aeroplane Flight Manual is supplemented as necessary with other data acceptable to the Authority if the approved performance Data in the Aeroplane Flight Manual is insufficient in respect of items such as:
 - (1) Accounting for reasonably expected adverse operating conditions such as take-off and landing on contaminated runways; and

(2) Consideration of engine failure in all flight phases.

(b) An operator shall ensure that, for the wet and contaminated runway case, performance data determined in accordance with JAR 25X1591 or equivalent acceptable to the Authority is used. (see IEM OPS 1.485(b).)

What are the obligations that an operator must comply with when using runways?

JAR–OPS 1.515 Landing – Dry Runways

(See Acceptable Means of Compliance to the OPS 1.510 and to the 1.515)

- (a) An operator shall ensure that the landing mass of the aeroplane determined in accordance with JAR–OPS 1.475(a) for the estimated time of landing at the destination aerodrome and at any alternate aerodrome allows a full stop landing from 50 ft above the threshold:
 - (1) For turbo-jet powered aeroplanes, within 60% of the landing distance available; or
 - (2) Not applicable
 - (3) Not applicable
 - (4) Not applicable
- (b) When showing compliance with subparagraph (a) above, an operator must take account of the following:
 - (1) The altitude at the aerodrome;
 - (2) Not more than 50% of the head-wind component or not less than 150% of the tailwind component; and
 - (3) The runway slope in the direction of landing if greater than $\pm -2\%$.
- (c) When showing compliance with subparagraph (a) above, it must be assumed that:
 - (1) The aeroplane will land on the most favorable runway, in still air; and
 - (2) The aeroplane will land on the runway most likely to be assigned considering the probable wind speed and direction and the ground handling characteristics of the aeroplane, and considering other conditions such as landing aids and terrain. (see IEM OPS 1.515(c).)
- (d) If an operator is unable to comply with subparagraph (c)(1) above for a destination aerodrome having a single runway where a landing depends upon a specified wind component, an aeroplane may be dispatched if 2 alternate aerodromes are designated which permit full compliance with subparagraphs (a), (b) and (c). Before commencing an approach to land at the destination aerodrome the commander must satisfy himself that a landing can be made in full compliance with JAR–OPS 1.510 and subparagraphs (a) and (b) above.
- (e) If an operator is unable to comply with subparagraph (c)(2) above for the destination aerodrome, the aeroplane may be dispatched if an alternate aerodrome is designated which permits full compliance with sub-paragraphs (a), (b) and (c).

JAR–OPS 1.520 Landing – Wet and contaminated runways

- (a) An operator shall ensure that when the appropriate weather reports or forecasts, or a combination thereof, indicate that the runway at the estimated time of arrival may be wet, the landing distance available is at least 115% of the required landing distance, determined in accordance with JAR–OPS 1.515.
- (b) An operator shall ensure that when the appropriate weather reports or forecasts, or a combination thereof, indicate that the runway at the estimated time of arrival may be contaminated, the landing distance available must be at least the landing distance determined in accordance with subparagraph (a) above, or at least 115% of the landing distance determined in accordance with approved contaminated landing distance data or equivalent, accepted by the Authority, whichever is greater.
- (c) A landing distance on a wet runway shorter than that required by subparagraph (a) above, but not less than that required by JAR–OPS 1.515(a), may be used if the Aeroplane Flight Manual includes specific additional information about landing distances on wet runways.
- (d) A landing distance on a specially prepared contaminated runway shorter than that required by sub-paragraph (b) above, but not less than that required by JAR–OPS 1.515(a), may be used if the Aeroplane Flight Manual includes specific additional information about landing distances on contaminated runways.
- (e) When showing compliance with subparagraphs (b), (c) and (d) above, the criteria of JAR–OPS 1.515 shall be applied accordingly except that JAR–OPS 1.515(a)(1) and (2) shall not be applied to sub-paragraph (b) above.

We therefore conclude that to schedule the use of a specific runway, the aircraft must be fully stopped:

- On a distance equivalent to 60% of the landing distance available for a runway dry; and
- if a wet or contaminated runway is expected at landing, the runway length must be increased by 15 % to compute the final landing distance.

8.6.4.4.3. THE FLIGHT CREW OPERATION MANUAL

We first notice that the expression "flooded" has not even been defined in Martinair's FCOM, nor has it been defined in KLM's FCOM.

We find the following in Martinair's BIM:

Braking Action	Motne Code	Friction Coëff. (µ)	Typical Runway Condition
GOOD	5	0.40 and above	. Dry runway. . Wet runway with good surface condition.
MEDIUM to GOOD	4	0.39 to 0.36	
MEDIUM	3	0.35 to 0.30	 Moderate to heavy rain on clear runway. Snow/Ice covered but sanded runway.
MEDIUM to POOR	2	0.29 to 0.26	
POOR	1	0.25 and below	 Slush or snow covered runway. Ice covered runway. Freezing rain. Drizzle on dusty runway. Standing water.

08 Description of braking action and runway condition

Interpolation between given values is permitted.

The reading of this table enables us to confirm that the Captain was supposed to consider, depending on meteorological information that was available to him, that the breaking action should be rather considered as "medium".¹³⁴

This is also what can be induced from the "approach briefing" made by the F/O before beginning the descent, and amended by the Captain when he asked for a "positive touchdown," as it is advised in the paragraph 3.3.5—15 of the FCOM.

The landing performances are defined in KLM's FCOM, in the chapter 6.4 "Landing performance."

The reader will note an important point of these few pages:

- The difference between the runway length required to schedule a specific runway during the flight preparation;
- and the actual landing distance depending on daily conditions.

We can find at paragraph 6.4.1 the "dispatch landing chart":

- in page 1, it indicates the procedure and the performance to be considered when the flaps are set at 50° ("flaps 50° setting"), and
- in page 2, it indicates the procedure and the performance to be considered when the flaps are set at 35° ("flaps 35° setting").

 ¹³⁴ Refer to Lijst 4 nr 9 vesrlag 1 : Document sent to the RvDL. Meeting minutes. 28 january 1993
 8. Braking action



We note that it was possible to plan landing at "maximum structural landing weight", which corresponds to 186,4 tons for both dry and wet runways (as defined by the JAR OPS 1.480—Terminology).

The table showing at paragraph 6.4.2 allows to plan, when in flight and during the approach briefing, the distance required for landing:

craft operation	ons manual DC10 6.4	LANDING PE	RFORMANCE ding Distan	1747 100
The Actual Conditions:	Landing Distances on this page are i	pased on the	e following	Reference
 Flaps 35. Landing W Standard Touchdown Braking t Standard Zero slop For the maximum This is 	eight: 160.000 kg flight techniques as per AOM 3.3. point at: 620 m for Flaps 35. 560 m for Flaps 50. echnique: Full brakes at nose gear (temperature. e. purpose of calculating Actual Land) available retardation force of the based on studies on the braking eff	ouchdown *	Landing not been taker n airline c	allowed
	REFERENCE ACTUAL LANDIN	G DISTANCE	5 (m)	persector.
	REFERENCE ACTUAL LANDIN Braking Action	GOOD	S (m) MEDIUM	POOR
	REFERENCE ACTUAL LANDIN Braking Action Tailwind 10 kt	G DISTANCE GOOD 1910	5 (m) MEDIUM 2460	POOR 3150
	REFERENCE ACTUAL LANDIN Braking Action Tailwind 10 kt Component 5 kt	G DISTANCE: GOOD 1910 1840	5 (m) MEDIUM 2460 2360	POOR 3150 3040
	REFERENCE ACTUAL LANDIN Braking Action Tailwind 10 kt Component 5 kt Zero wind	G DISTANCE: GOOD 1910 1840 1760	5 (m) MEDIUM 2460 2360 2250	POOR 3150 3040 2890
	REFERENCE ACTUAL LANDIN Braking Action Tailwind 10 kt Component 5 kt Zero wind Headwind 10 kt	G DISTANCE: GOOD 1910 1840 1760 1630	s (m) MEDIUM 2460 2360 2250 2070	POOR 3150 3040 2890 2630
	REFERENCE ACTUAL LANDIN Braking Action Tailwind 10 kt Component 5 kt Zero wind Headwind 10 kt 20 kt	G DISTANCE: GOOD 1910 1840 1760 1630 1500	5 (m) MEDIUM 2360 2250 2070 1890	POOR 3150 3040 2890 2630 2370
	REFERENCE ACTUAL LANDIN Braking Action Tailwind 10 kt Component 5 kt Zero wind Headwind 10 kt 20 kt Component 30 kt	G DISTANCE: GOOD 1910 1840 1760 1630 1500 1370	5 (m) MEDIUM 2460 2360 2250 2070 1890 1710	POOR 3150 3040 2890 2630 2370 2110

+20

+10

+6 -6

+60

+20

-15

+30

+30

+110

-100

+30

+10

+8 -8

+80

+25

-20

+360

+100

+360

-150

+40

+10

+10 -10

+100

+40

-30

+770

+190

+770

-200

Maintain a margin of 200 m over the Actual Landing Distance.

Per 1 kt ABOVE V_{TH} + 5 kt

Per 1000 ft ABOVE Sea Level

Per 1 kt

Per 1°C ABOVE Std

Per 0.1% DOWN Slope

No reverse eng 2

No reverse

Flaps 50

UP

No reverse eng 1 or eng 3

· ~000-

Date	:	1	DEC	1992	REVERSE SIDE	DC-10	AOM:	6.4.2	
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FAS

CROSSWIND

ELEVATION

SLOPE

REVERSE

THRUST

FLAPS

TEMPERATURE FIELD

It is important to underline that the results are established with only 50% of the maximum braking action capability and that the touchdown point is at 560 m (with the flaps 50° configuration) from the threshold.

Based on a braking action classified as « Medium », the reference landing distance is:

Wind: 150° / 20 kt equivalent to 15 kt headwind

→ Reference landing distance: 1980 m

The corrections for the deviating conditions from the reference evaluation are:

Outside temperature:	15°	No correction
Cross wind:	12 kt	+ 120 m
Airport pressure altitude:	≈ 50 ft	No correction
Aircraft landing weight:	161 T	+ 110 m
Runway slope:	≈ 15 ft/2500 m	No correction
Reversers:	1 & 3 only	+ 100 m
Flaps:	50 °	- 150 m

The resulting corrections are: +180 m.

 \rightarrow That means a landing distance of $\frac{2160}{2160}$ m.

One has to keep in mind that we must consider this value as established for a touchdown at 560 m from the threshold, while the normal technique, as described in paragraph 3.3.5 of the FCOM (vol II), should enable a touchdown in the 300 m envelope.

The landing performance analysis as provided by McDonnell Douglas concluded that a landing distance below 2000 meters was necessary according to the actual conditions.

One of the questions that remain unanswered is, once more, the way the pilots interpreted the expression "flooded."

No crew member did, at any moment, express any doubt regarding this term; each crew member — the captain, the first-officer, and the flight-engineer — understood it the same way.

And as the Experts highlight it, these considerations are also the ones indicated in the paragraph 8 of the meeting minutes the 28 January 1993.¹³⁵.

They all considered the runway to be wet, but not contaminated.

¹³⁵ Meeting minutes N° BVO/92-12/12 – Extension 63291 – 28th january 1993 – Subjects : 2nd coordination meeting §8 : Braking action and the term « Flooded »

[«] Traffic control mentioned « Runway flooded » to both the B-767 and the Dc10.

This was confirmed by the NB-767 and apprently interpreted as « wet runway » with b/A medium

Apparently, after the landing, the B-767 did not see any need to comment about this, neither to the TWR nor to the DC-10.

Given their own statements, the DC-10 apparently made the same assumption.

It will be checked with/via J.M. da Silva what the meaning is of this non standard expression. »

8.6.4.1. THE HORIZONTAL FLIGHT MANAGEMENT DURING THE APPROACH

8.6.4.1.1. THE USE OF THE CHART

As one can see it on the Jeppesen chart, there are two different approach flight paths:

1) First, the one coming from a point at 14 DME on the 291° radial of the VFA VOR.

This flight path must cross the 6 DME VFA VOR initial approach fix at, or, above 3000 ft, then, via a right turn to a 291° route, descent to 2000 ft to again turn right at 10 DME, and finally come back to the 111° radial for the final approach path.

The minimum safety altitude (MSA) on this sector is 3000 feet and it is the reason why descending under this altitude is only allowed in the holding pattern;

The final descent should begin at 7 DME VFA.

2) The second one, designed as "Alternative procedure", via overhead the VFA VOR at, or, above 4000 ft.

The route to follow then is outbound via:

- the 281° radial for CAT A & B aircraft, or
- the 269° radial for CAT C & D aircraft

until crossing 8 DME then turn right to be established on the final 111° radial.

This difference of radial (269° instead of 281° radial) is due to the speed used to establish the last final turn which radius will be different.

The DC10 is classified as a CAT D aircraft, which means an approach speed between 141 knots and 166 knots.

The CAT C/D speeds are greater than the CAT A/B speed, consequently, the outbound radial should provide a greater radius of final turn. This is the case with the outbound radial of 269° as indicated on the Jeppesen chart.

The real flight path of the MP495 was performed according to the alternative procedure for CAT C & D aircraft¹³⁶.

The final turn is performed with the autopilot engaged and acting in Heading Select (HDG SEL) mode.

In this configuration, the bank angle is set at 25°, matching with the value used to define this turn.

¹³⁶ *Captain's statement page 4*

But, with a wind coming from the south/south-east, the path on ground will obviously "overshoot" the approach radial and a correction should be performed to come back as soon as possible on the centerline or on the scheduled radial (here VOR-VFA radial 111°).

According to the radar data analysed by the experts and the chart issued in the official report Annex 12: "Plotting Radar da trajectoria da aeronave", the position of the aircraft at the end of the final turn was (at a maximum of) about 0,6 [nm] left of track and reduced gradually towards the intersection with the extended centre line of runway 11 at around 1 [nm] before the runway¹³⁷.



¹³⁷ Source: Annex 12 of the Final Report of Accident by DGAC Portugal ("RELATIORIO FINAL DO ACIDENTE OCORRIDO NO AEROPORTO DE FARO – PORTUGAL EM DE DEZEMBRO DE 1992", Relatorio No. 22/ACCID/GPI/92).

At this point, the F/O had to handle two different issues simultaneously:

- The overshoot requiring to turn right towards at least a heading of 150° and at around 1 [nm] before th runway to turn left on heading 125° to balance the wind and to establish the mandatory drift angle;
- The handling of the early stage of the final descent.

These two actions were performed in accordance with the BIM.

Moreover, a correction of this magnitude is not a problem of concern, since the navigation aids are available (as it was the case) and as soon as the visual references are effective (according to the Captain's statement, it was true when crossing more or less 1.200 [ft] above the ground¹³⁸).

According to the Captain's statement, the flight was on the extended centerline of the runway at 200 [ft]¹³⁹.3

The Commission of Investigation issued the chart in the official report Annex 12: "Plotting Radar da trajectoria da aeronave".

The Claimants' advisors team used also this chart to support their comments.

Following the remark referenced under 4.2.5.11 on the "Review and Remarks and Questions of the Claimants after the issuance of the interim report V17", the Experts decided to clarify and to reformulate the note of the page 105 of this interim report V17 and to answer the above remarks.

The main challenge is to try to determine precisely the position of the aircraft related to the perfect flight path to be followed during this approach.

Three main points are to be considered:

 a) the Air Traffic Control (ATC) surveillance radar used by NAV Portugal (Air Navigation Service Provider ANSP in Portugal) is a tool to separate aircrafts relative to and between each other;

ATC takes any position error of the surveillance radar into account when defining separation standards.

b) the ATC radar data used by NAV Portugal has also been used by the Commission of Investigation to determine the position of aircraft relatively to the ground;

The absolute position of an aircraft derived from ATC surveillance radar is not necessarily fully aligned to the corresponding geography. The resulting track of an aircraft derived by means of ATC radar compared with a ground based reference track (like 111° radial of a VOR) definitely has an error which is not known in this specific case.

c) the positioning and navigation accuracy of the aircraft itself using INS, VOR/DME, etc.:

¹³⁸ Captain's statement – page 5

¹³⁹ Captain's statement – page 6

During cruise, the usual procedure (VOR/DME on "Autotune")¹⁴⁰ for the best combined resulting navigation accuracy is, as much as possible, a dual DME updating.

At the very last part of the flight and according to the approach procedure to be performed (VOR/DME runway 11), the FARO VOR/DME was manually selected on both receivers. In this case, the resulting navigation accuracy become the one of the VOR/DME.

That demonstrates that the use of the recorded data ("mixed of inertial platform data such as the Euler angles (roll, pitch and yaw), ground track, drift angle, magnetic heading angle, longitude and latitude, together with inertial acceleration measured in the body of frame reference")¹⁴¹ to derive the flight path is the best solution to limit the errors to know the position of the aircraft.

To further analyse the lateral and vertical alignment of the flight MP495 towards runway 11 at Faro, the Experts have conducted a detailed analysis based on the available radar data positions from the official Annex of the RoA.

8.6.4.1.2. ANALYSIS OF RADAR DATA OF FLIGHT MP495

8.6.4.1.2.1. GENERAL STATEMENTS

This analysis is intended to visualize the track of the flight MP495 on 21. December 1992 based on radar data provided by the court to the experts. The source for this analysis has been in the official Annex to the original report of accident (RoA) by the Portuguese Commission of Investigation provided by the court (details are in annex 5 of the Annex to the RoA).

The documentation provided to the experts by the court does not include any details on the radar sources itself (like geographic position, type of radar primary and/or secondary surveillance, update rate, position errors etc.).

As the analysis of the final flight is of particular interest, the experts started to use the radar data at RADAR time 07:11:29 [hh:mm:ss] until 07:32:59 [hh:mm:ss] as the last data datum.

The radar data has been provided with a five (5) seconds update until touchdown of the aircraft at 07:32:59 [hh:mm:ss] RADAR time.

The magnetic declination at Faro on 21.12.1992 has been 5.31°W (changing by 0.12° East per year).

¹⁴⁰ Automatic selection of the station for the best updating of the INS position

¹⁴¹ NLR final report CR 93080C page 79 and the text, chapter 2.2.1 pages 17 and 18.

8.6.4.1.2.2. ACCURACY OF THE RADAR DATA

Generally, as a rotating radar deliver targets (here: aircraft) positions known as "plots" in polar coordinates representing the range and bearing ("lateral position") of the target (here: aircraft).

The absolute accuracy of the resulting "plots" is highly influenced by the angular accuracy of the radar and the distance to the radar position (which is not known in this case).

The induced error (in absolute terms) of this angular accuracy becomes larger the further away the target (here: aircraft) is from the radar origin.

The error associated of the range measurement of the radar stays more less the same over the maximum coverage area of the radar.

In other words, the further away the target (here: aircraft) is from the radar origin, the larger the bearing error appears in absolute terms. This is why we have a changing lateral position quality of the radar plots during the course of the flight.

It can be assumed, that in 1992 the <mark>available radar data has been subject to radar</mark> tracking.

A radar tracker is a component of a rotating air surveillance radar system that converts consecutive radar observations ("plots") of the same target (here: aircraft) into tracks.

The radar tracker is also able to use consecutive plots to estimate the current speed and heading of the aircraft.

It can also be assumed that in 1992 the data of only one radar at any given time had been used as data source (so called "mono radar tracking").

Mono radar tracking refers to the use of surveillance data from single radar only. This technology has been in place in Portugal at the time of the accident by the air navigation service provider (here NAV Portugal).

At 07:20:29 [hh:mm:ss] RADAR time the original radar data set ("magenta radar plots" in figures) started to include a second set of radar data positions in the data set ("cyan radar plots" in figures).

From data analysis it appears that this second data set ("cyan") is identical to the original positions in principle but has been subject to a lateral position correction.

The measured relative difference between both radar tracks is in the range between 150 [m] and 300 [m].

No quantitative statement on the absolute lateral position accuracy of the radar data can be made.

8.6.4.1.2.3. LATERAL ANALYSIS OF THE RADAR DATA

The radar data show that the aircraft flew from north to south, crosses the Faro airport midfield and followed the prescribed (alternative) routing towards the nonprecision VOR/DME approach to Faro airport (see figure 1).

The radar data are complete and every five (5) seconds a position report is available; no single position report is missing throughout the data set. In figure 1, the areas with orange circles mark areas with large lateral deviations within the radar track (orange circles).

These effects cannot be fully explained at this point.

It is assumed that these deviations are caused by radar tracking alignments or possibly by masking or shadowing the aircraft bottom secondary surveillance SSR transponder antenna because of the banking aircraft (which is not for sure) towards the interrogating secondary SSR radar.

In both cases, the strong modification of the aircraft trajectory in such a short time is operationally not possible and has no further relevance to the accident and therefore does not need to be considered any further.

Google

An interpolation of these radar position points is acceptable.

Google Earth projection) data (in (Magenta: Original radar track; Cyan: Corrected radar track)

The radar data for the final approach segment from Initial Approach Fix (IAF) towards the runway is complete and the data plots generally match the runway 11 around the touchdown area on runway 11.





Figure 2: Lateral Flight Profile based on radar data (from IAF to touchdown, zoomed in Google Earth projection) (Magenta: Original radar track; Cyan: Corrected radar track)

The corrected radar data track (cyan colour) ends up about 150 [m] south of and about 900 [m] from the threshold of runway 11 (see orange circle). The original radar track data (magenta colour) ends up about 90 [m] north of and about 1.200 [m] from the threshold of runway 11 (see orange circle).



Figure 3: Lateral Flight Profile based on radar data (final segment, zoomed in Google Earth projection) (Magenta: Original radar track; Cyan: Corrected radar track)

As the aircraft has reached the runway 11 (around 350 m to 400 m beyond runway threshold) it can be assumed that the last radar datum should be somewhere around this position. It has therefore been assumed that the corrected ("cyan") radar track (corrected by NAV Portugal) is the most "suitable" radar track; this corrected "cyan" track is identical in principle with the "magenta" track but shifted by a lateral correction factor.

Consequently, the "cyan" track has been shifted to the North to match the runway 11 centre line as best as possible (see shifted "green" track in figure 4).

J.-L. Françon, L. Bloncourt, D. Kügler, Experts



Figure 4: Lateral Flight Profile based on radar data (final segment, zoomed in Google Earth projection) (Cyan: Corrected radar track; Green: Shifted corrected radar track)

In a next step the green track has been again shifted to the west end of the runway (to become a "purple" track) so that the last radar datum (see orange circle in figure 5 and 6) matches around the touchdown point of flight MP495.



Figure 5: Lateral Flight Profile based on radar data (final segment, zoomed in Google Earth projection) (Cyan: Corrected radar track; Purple: Shifted to touchdown point corrected radar track)



Figure 6: Lateral Flight Profile based on radar data (final segment, zoomed in Google Earth projection) (Purple: Shifted to touchdown point corrected radar track)



Figure 7: Lateral Flight Profile based on radar data (final segment, zoomed in Google Earth projection) (Purple: Shifted to touchdown point corrected radar track)

From this radar data analysis it can be assumed, that the flight MP495 had been laterally aligned with the extended centre line of runway 11 (quite late) shortly after the intersection of VOR radial 111° and the runway extended centreline of 106° at around 0,8 [nm] (or 1.500 [m]) from touchdown (see figure 7). Assuming a three (3) degree glide path of the flight the corresponding height above ground is around 250 [ft].

8.6.4.1.2.4. VERTICAL ANALYSIS OF THE RADAR DATA

The vertical information of each radar plot has been derived via the secondary surveillance radar interrogations of the airborne transponder (SSR-Mode C) of flight MP495; the resolution of the vertical information is quantized to 100 [ft] increments (see figure 8).

It can also be noted, that from this analysis the vertical alignment of the aircraft was quite as expected during the final 5 [nm] of the approach with some vertical movement in the final stage of the approach.



Figure 8: Vertical Flight Profile based on radar data



This analysis of the available radar data supports the assumption, that flight MP495 was laterally aligned with the extended centre line of runway 11 (quite late) shortly after the intersection of VOR radial 111° and the runway extended centreline of 106° at around 0,8 [nm] (or 1.500 [m]) from touchdown and was established on the extended centre line of runway 11 at around 250 [ft], which is in accordance with Captain's statement¹⁴² indicating that the flight was on the centre line of the runway at 200 [ft].

The Experts are also confident regarding the conclusions of the NLR report about the position of the aircraft which was aligned, on very short final, on the center line of the runway below more or less 200 [ft].

Moreover, this conclusion matches with the Captain's statement¹⁴³ indicating that the flight was on the center line of the runway at 200 [ft] and the radar data analysis conducted by the experts.

Generally, all parties agree on the fact that there was an overshoot of MP495 at the end of the final turn towards the radial 111° at (a maximum of about) 7 [nm] from the FARO VOR/DME.

The Experts have to recall, that the pilots reported to have the runway in sight from 4 NM (or 1.200 [ft]) and confirmed to ATC at 1.100 [ft]), and that this lateral overshoot is not a cause of the accident.

¹⁴² Captain's statement – page 6 (Lijst 4 map 1on 4 pdf page 19)

¹⁴³ Captain's statement – page 6 (Lijst 4 map 1on 4 pdf page 19)

The following chart¹⁴⁴ provided by the NLR (see final report CR93080C) confirms the Captain's statement and the radar data analysis of the experts about the position of the aircraft on short final.

<u>Note</u>: This chart of the final NLR report CR93080C has been used following the Claimants advisors' team correct indications in the Interim Report V17.



¹⁴⁴ Source: 10039189-List-4-map-4-sur-4.pdf (page 85)



8.6.4.1.3. THE JEPPESEN CHART

This circle provides the minimum safety altitude (MSA) according to the position of the aircraft with respect to the VFA VOR:

- North of the radials 106°/286° of VFA, the MSA is 3000 feet (QNH)
- South of the radials 106°/286°, the MSA is 1400 feet (QNH)

The circle is the 25 nm circle around the VFA VOR

This path is at the same time the west holding pattern but also the flight path to be used for the traffics coming from the west and landing in Faro on runway 11. These traffics must cross the position 14 nm VFA DME at or above 3000 feet QNH with a minimum of 2000 feet QNH then leave 2000 ft QNH at 7 nm VFA DME on the radial 291°.

This path is called "Alternative procedure".

The traffics must cross overhead VFA VOR at or above 4000 feet then fly either the radial 281° for the aircrafts classified as category A or B or the radial 269° for the aircrafts classified as category C or D.

These boxes are the tool used to check the final descent slope.

The final descent begins at 7 nm VFA DME then should cross 6 nm VFA DME at 1730 feet QNH, and so on.

The pilots use the word "window" to refer to the association of a distance (DME) and the respective altitude.

This is the description of the flight path to be followed in case of go around procedure.

This is the Minimum Descent Altitude at which the visual reference must be in sight to be cleared to continue the approach.

This box gives the average rate of descent on a 5% slope for various ground speeds.

For example, for a ground speed around 135 knots (*Approach speed 144* minus wind component of 11 knots = 133 knots), the average rate of descent should be around 685 feet per minute.

(8)

The turn in final is computed according to the speed used for the category of aeroplane involved.

These Categories are defined below with a constant bank angle of 25° and no wind effect.

This is the reason why for the aircraft classified in category C or D, the outbound radial is different than the one used for category A or B aeroplanes.

8.6.4.1.4. AIRCRAFT APPROACH CATEGORY (ICAO)

The reference is the document n° 8168: Procedures for Air Navigation Services - Volume I - Flight Procedures:

1.3 CATEGORIES OF AIRCRAFT

- 1.3.1 Aircraft performance has a direct effect on the airspace and visibility required for the various manoeuvres associated with the conduct of instrument approach procedures. The most significant performance factor is aircraft speed.
- 1.3.2 Accordingly, categories of typical aircraft have been established. These categories provide a standardized basis for relating aircraft maneuverability to specific instrument approach procedures. For precision approach procedures, the dimensions of the aircraft are also a factor for the calculation of the obstacle clearance height (OCH).
- For Category DL aircraft, an additional obstacle clearance altitude/height (OCA/H) is provided, when necessary, to take into account the specific dimensions of these aircraft (see Part II, Section 1, Chapter 1, 1.3).
- 1.3.3 The criterion taken into consideration for the classification of aeroplanes by categories is the indicated airspeed at threshold (Vat), which is equal to the stall speed Vso multiplied by 1.3, or stall speed Vs1g multiplied by 1.23 in the landing configuration at the maximum certificated landing mass. If both Vso and Vs1g are available, the higher resulting Vat shall be applied.
- 1.3.4 The landing configuration that is to be taken into consideration shall be defined by the operator or by the aeroplane manufacturer.
- 1.3.5 Aircraft categories will be referred to throughout this document by their letter designations as follows:

Category A:	less than 169 km/h (91 kt) in	dicated airspeed (IAS)
Category B:	169 km/h (91 kt) or more	but less than 224 km/h (121 kt) IAS
Category C:	224 km/h (121 kt) or more	but less than 261 km/h (141 kt) IAS
Category D:	261 km/h (141 kt) or more	but less than 307 km/h (166 kt) IAS
Category E:	307 km/h (166 kt) or more	but less than 391 km/h (211 kt) IAS
Category H:	see 1.3.10, "Helicopters".	

For example:

- The Boeing B737 or the Airbus A320 or the Airbus A380 are classified as Category C aeroplanes.
- The Boeing B747 or DC10 are classified as Category D aeroplanes.

The conclusion is that the MP 495 must follow the 269° radial.

8.6.4.2. THE VERTICAL FLIGHT MANAGEMENT DURING THE APPROACH

The descent path management was apparently well performed:

- Anticipation of the key points,
- Flight data checks when overflying these key points,
- Evaluation of the position of the aircraft regarding the required flight path,
- Corrections to be initiated.

However, recorded data show us:

- A position approximately 35 feet above the flight path (difference between the DFDR as provided by the NTSB and the perfect descent slope¹⁴⁵) at around 07:31:25 UTC with a nearly constant indicated speed; "nearly" because N1 was slightly above the value that is usually necessary for a flaps 50° configuration. The adjustment made by the pilot results in a correct position compared to the required flight path but generates the following situation.
- A position approximately 50 feet below the flight path at around 07:31:45 UTC with, in this case, a clear increasing indicated air speed combined with a decreasing N1.

This situation is abnormal: it shows incoherence in the trajectory data that can only be explained with outside parameters (as the flight is at this moment managed by the autopilot).

A position below the flight path with increasing air speed would be logical if N1 was constant or increasing.

The descent gradient was not really different from usual values (not enough to be noticed); an outside disturbance caused what we obviously see on the reports.

An adjustment was made to get back on the vertical flight path.

- A position approximately 70 feet below the flight path at around 07:32:00 UTC with both a speed decrease as well as a N1 decrease.
 The autopilot is now disengaged. The manual adjustment enables the pilots to get back to the required vertical flight path.
- Finally, a position 30 feet below the vertical flight path at 07:32:40 UTC at about 150 feet above ground level, with an obvious speed decrease and a major N1 increase.

This is important because:

- This is the only situation flagged (CVR) by the Captain who was monitoring the approach process;
- it shows the entering in a descending phase in which, despite the important thrust adjustment, the speed decreased rather strongly.

¹⁴⁵ The « perfect descent slope » [or ideal descent slope] is the slope as indicated in the AIP, in this case, 5% from a point placed at 50 ft above the threshold. For this slope, refer to the Jeppesen chart establish according the ICAO Annex 14 and PAN OPS 3, indicating the ideal descent gradient of 5%.

From the Experts' point of view, this is what worried the Captain and forced him to comment on the position of the aircraft and flag the position below the vertical flight path, whereas he did not do it before.

Here after, are the variations of the final descent's characteristics.

Important: The vertical speed values are computed. This is why one must keep it in mind and be cautious when taking these values into consideration.



Computed vertical speed¹⁴⁶

The computed vertical speed value at touchdown is around 850 feet per minute.

¹⁴⁶ From the provided NTSB chart (DFDR factual report DCA 93RA-011 February 12th, 1993), the actual height has been put in front of time reference and the vertical speed is then computed each 5 secondes.

8.6.4.3. THE ACCIDENT IN ITSELF

The Experts will underline only one element regarding this part of the flight as it is not the mission they received from the Court.

The accident is due to the destabilization of the flight at low altitude.

8.6.4.4. THE "G<mark>O AROUND" PHILOSOPHY</mark> AT THE TIME OF THE ACCIDENT

This question is a matter of pilot's and airline's culture.

At the time of the accident, "go around" was being perceived to be equivalent to "unable to manage" the elements, "being pointed out" by the community.

The only case for which the "go around" was accepted, was during the low visibility operations, such as fog, because managed under autopilots' inputs.

It has been a huge work for the airlines safety departments to change the way "goaround" procedures would be considered by the pilots.

Another factor is the decision of the Captain to divert to Lisbon in case of missed approach.

From what we call now the "Human Factors" point of view, this situation is considered as one of the heaviest situations to manage.

8.6.5. THE RECORDERS

8.6.5.1. CVR ANALYSIS

The reference used by the Experts is extracted from the files sent to the Experts by the Court.¹⁴⁷.

The time reference used below is the one indicated by the transcription and described as UTC reference.

The lessons:

- 1 The crew behavior and coordination are good.
 - a. For example, the conversation at 06:59:58 UTC shows a good level of professionalism;
 - b. Also, the captain's behavior regarding the crew briefing is good: the Captain let the F/O perform his briefing and clarify some points

¹⁴⁷ Refer to the document list and to the document provided on the Lijst-2-map-3-sur-3

important from his point of view, such as the technic for landing or the diversion to Lisbon in case of missed approach;

- 2 The management of the cockpit is quite good until 800 feet (radio-altimeter)
 - a. The crew is aware of the quite bad weather conditions;
 - b. The choice of the flaps setting during the briefing is made with respect to a wet runway;
 - c. The flight path follows the Jeppesen chart;
 - d. The slope management is good not only from the procedure point of view but also from the airmanship point of view.
- 3 Psychological aspects
 - a. Even if the Experts cannot evaluate it using an audio record, they estimate that the level of stress in the cockpit increased strongly in the last part of the approach;
 - b. The captain forgot to check the "500 ft" window and the F/E had to remember him;
 - c. The F/O make a confusion between the "windshields" and the "wipers";
 - d. These two points are the demonstration that the cockpit level of stress raised significantly after crossing 800/700 feet radio-altimeter;
 - e. Other issues will be analyzed later on, based on pilot's specific actions recorded on the DFDR.

8.6.5.2. ANALYSIS OF THE COCKPIT VOICE RECORDER TRANSCRIPTION.¹⁴⁸

TIME UTC	ALTITUDE	WHO ?	CONTENT	COMMENT
06:52:52		F/O	End of approach briefing: - Flaps 50° - manual crew coordination procedure - wet runway	 The crew anticipates a wet runway It is not possible to perform another type of approach because with a KSSU DC10, the VOR-DME approach can only be performed manually or using the basic modes (HDG, VRT SPD) of the autopilot.
06:53:22		CPT	The 461 is standing by for descent	(inside taking with the crew)
06:53:56		CPT	We have to look at these things	Probable comments about echoes on the radar
06:53:59		СРТ	And here are the wipers	Seems to be a test for the wipers (no limitation) And this shows that the Captain anticipates the need for wipers later on during the approach
06:54:00		F/O	Roger	
06:54:08		F/E	237, 195, 161, 139	Different airspeeds to manage during the deceleration towards the landing configuration: 237 : VMAN UP/RET 195 : VMAN Flaps 0°/TAKE OFF 161 : VMAN 22°/TO 139 : REF Flaps 50°/LAND
06:54:25		CPT F/O	set set	
06:55:54		CPT	You have to make it a positive touchdown then	This shows us that the crew was aware of at least a wet runway
06:55:56		F/O	ja	
06:56:09		F/O	That happens sometimes, even if you don't want it	Seems to be a joke, showing that the crew is NOT stressed
06:56:11		CPT	ja	
06:56:51		ATC	"MP 495, proceed direct to Faro"	Usual normal procedure
06:56:55		MP495 (CPT)	"Proceed direct to Faro, 495, thanks"	
06:57:01		F/O	direct Faro	
06:57:02		CPT	ja	

¹⁴⁸ Lijst 2-map-3sur-3

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06:59:04	F/O	There is a PAPI over there	Seems to be considerations between the CPT and the F/O about
06:59:05	F/O	runway lights, centerline lights but no approach lights	some specificities of the approach and the runway : - <u>Localization of the PAPI</u>
			 No approach lights Approach with an offset to the left
06:59:12	F/O	Someoffset, isn't it, to the left	Seems to consider the offset radial of approach path
06:59:15	CPT	Yes, a little bit	
06:59:16	F/O	5°	
06:59:58	CPT	I'm off this frequency for a while	The captain contacts the airline operations on ground.
07:00:28	CPT	I'm back again	This procedure shows a good level of professionalism
07:00:29	F/O	Roger	
07:00:33	F/O	Discussion about the parking position	Anticipation for the operation on ground. On DC10, the ground taxiing is performed only from the left side (Captain). The F/O seems to anticipate his duty after the landing.
07:00:55	ALL	F/O Descent check-list	Descent check-list
to		F/E Descent check-list	
07:01:23		F/E Windshield anti-ice	
		CPT Set	
		F/E Exterior lights	
		Ul'I SCI	
		F/E Annunciator lights	
		CPT Checked here	
		E/F Terrain clearance	
		CPT Checked	
		E/F Approach preparation	
		CPT Completed	
		F/O Completed	
		F/E Descent check-list completed	
07:01:26	CPT	Just a beacon, isn't	
07:01:29	F/O	Yes, that one is behind the runway	
07:01:31	CPT	behind the runway, so that is	
07:01:56	F/O	Will you ask descent clearance	
07:02:00	CPT	"MP495 request descent"	Descent clearance
to	and	"MP495, contact now Faro 119,4, good day"	
07:02:19	ATC	"Understand, 495, 119,4 Faro Approach, good day"	
		"495, descent FL 250"	
		"495 leaving level 370 for level 250"	
07:02:25	F/O	Armed, set 250	

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07.02.28	CPT	I'm listening out what we	
07:02:47	MP461	Communication to MP461 (B767 landing in Faro 5 minutes before	RWY 11 in use 150°/15 kt. visi 2500m_thunderstorm
01.02.11		MP495)	3/8 500
			7/8 2300
			1/8 CB 2500
			Temp 13
			QNH 1013
			Transition level- 0 50
07:03:39	CPT	The captain repeats the message sent to MP461 and confirm the	Minimum Visibility is confirmed and compatible with the visibility
		minimum visibility for a VOR/DME approach RWY 11 : 2000 m	issued by ATC
07:04:17	CPT	If we don't make it, we go immediately to Lisboa	This gives the CPT's action plan : he does not want to wait but to
			divert immediately to Lisboa in case of go around
07:04:22	CPT	But it shouldn't be a problem	Shows us that the CPT considers the situation as normal
07:05:56	ATC	"495, cleared FL 70"	
07:06:03	FO	Level 70 set and armed	
07:06:32	CPT	I don't see anything on the radar at all	Either the radar antenna is set at a too low angle or the echoes are
			quite important (crossing a cloud with heavy rain)
07:06:45	F/O	Here to the right	Seems to turn right may be to avoid a cloud (?)
07:08:32	ATC	Martinair 495, good morning	New weather. The only change is about wind :
		Continue as cleared, report approaching FL 070	150° at 18 knots
		Presently number 2, no delay expected	
		Runway 11 in use the wind from 150°, 18 knots	
		Visibility 2500 meters	
		Present weather thunderstorm,	
		The amount of clouds 3/8 at 500 feet, plus 7/8 at 2300 feet plus 1/8	
		cumulonimbus at 2500 feet	
		Temperature 16	
		QNH 1013	
		Transition level 50	
07:09:13	CPT	Copied OK. Number 2	
07-00-04		And 1013	
07:09:24			I ne F/E is setting the pressurization
07:09:25		ja Wa con so at the and of the supuration	Maaning that the contain plane to cuit the manual not write the
07:09:54	GPT	we can go at the end of the runway	taxiway C but the taxiway P
07:09:56	F/O	ја	
07:11:41	Public	Ladies and gentlemen, in about minutes	No comment
	Address		
07:12:05	ATC	MP 461, confirm passing altitude and distance	Showing that the controller is not using a radar but classical
			separation

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07:12:09	MP461	Out of 85 for 4000 feet, present out of 20 nautical miles	MP 461 is inbound Faro VOR at 20 nautical miles
07:12:14	CPT	20 NM	
07:12:22	F/O	What ?	
07:12:23	CPT	He is 20 NM in front of us	This is the distance between the MP461 and the MP 495 meaning more or less 6 to 7 minutes
07:12:25	F/O		
07:12:28	CPT	ja	
07:12:45	F/O	It's raining cats and dogs over here	The weather is quite bad and this shows us that the crew was aware of the weather situation
07:12:46	CPT	ja	
07:13:07	СРТ	We should have arrived half an hour earlier	Possible meaning that the weather conditions are worst than 30 minutes ago or also that without the problem with reverser n°2, at this time they should be already on ground
07:13:10	F/O	Yes, you can say that again	
07:13:13	CPT	ja	
07:13:21	MP461	MP 461, can we proceed approximately 5 miles over left to avoid build up?	Confirm the fact that a lot of CBs are in the area
07:13:33	ATC	Affirm, confirm your are flying down the INS to 5 miles finals ?	The ATC controller did not understand the request. But this answer shows also that there are probably CBs on the S-S- W of the airport, because the Controller seems to understand that a report direct to a position 5 miles on the extended centerline of the runway using INS is acceptable.
07:13:42	MP461	Negative, proceeding 5 miles left of track to avoid build up	Means finally a track south-east of the normal one
07:13:47	ATC	OK, so report abeam overhead for a VOR-DME procedure	Meaning that the ATC clears the MP461 to pass south of the airport to join directly the outbound radial of the VOR-DME procedure
07:13:54	MP461	We'll proceed overhead when we are clear and we have present out of 60 for level, correction, for 4000 feet and we are $\frac{1}{2}$ out 4 NM	
07:14:07	ATC	Roger, sir, report overhead for starting the VOR-DME procedure outbound radial 125 sorry, 269	
07:14:14	MP461	Roger, outbound 269 call you overhead MP 461	The MP461 is obviously following the "alternative procedure"
07:15:09			A cabin attendant enters the cockpit
07:15:13	Cabin Attendant	How is the weather ?	
07:15:14	CPT	It's a lousy weather over there	Confirmation that the crew is aware about the weather conditions
07:15:15	Cabin Attendant	Lousy weather ?	
07:15:16	CPT	ja	
07:15:16	Cabin attendant	I'm going again	

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07:15:25	F/O	Approach check-list	According to the DC10 standard procedure, this check-list is performed as soon as the main altimeters are set on QNH,
07:15:29	F/E	Approach check-list	
07:15:30	F/E	No smoking Fasten seat belts	
07:15:32	CPT	Auto, on	The seat belt s sign will automatically turn ON when the landing gear will be extended
07:15:34	F/E	Exterior lights	
07:15:35	CPT	Set	
07:15:36	F/E	Thrust rate Computer	Automatic calculation of the thrust available
07:15:38	CPT	Set	On G/A to prepare a possible missed approach
07:15:44	F/E	Landing data	
07:15:46	F/O	Checked and set	Speeds for landing
07:15:50	CPT	Set, ja	
07:15:52	F/E	Radio altimeter	
07:15:55	CPT	Checked, zero set	According to the Martinair procedure,; it is a normal setting for a VOR-DME approach
07:16:00	F/O	Ja checked zero set	
07:16:03	F/E	Speed brakes	
07:16:04	CPT	Retracted	Extend the flaps and slats with speed brakes extended was forbidden
07:16:06	F/E	Navigation systems	Possibility to insert specific information such as predetermined approach in the navigation computer. It was not the case here
07:16:07	CPT	set	
07:16:08	F/O	set	
07:16:14	F/E	Crew briefing	For landing, allowing if applicable to add some specific elements
07:16:16	F/O	Completed	

07:16:17	СРТ	Do you want to start with 269 radial ?	This is what is called a task interruption. And this the confirmation that the MP495 is using the alternative procedure as MP461 did it a little bit earlier
07:16:24	F/O	Yes in a momentthat's OK, yes	The Flight is just overflying the VOR
07:16:32	F/E	Sorry, crew briefing	Good demonstration of professionalism. The F/E comes back to the item which was not answered because of the task interruption
07:16:33	F/O	Is completed	
07:16:36	F/E	Stand by for altimeters	Not already compared
07:16:38	F/O	Altimeters	
07:16:42	F/E	Approach check-list completed	
07:17:10	ATC	MP461 Confirm distance	

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07:17:14		MP461	Approaching overhead 2.5 miles out, 4000 feet	
07:17:18		ATC	Roger, cleared for a VOR/DME approach runway 11, 269 outbound.	
			report leaving 4000.	
07:17:27		MP 461	Roger call you leaving 4000 and outbound 269	
07:17:35		ATC	MP495 confirm distance to run	
07:17:38	FL 090	MP495	Distance to run is 26 and we are out of 90 for 70	The MP495 just passed flight level 90
07:17:54		MP495	Did you copy, 495	
07:17:56		ATC	Affirm	
07:17:59		TP120		Traffic departing from Faro. The ATC organize the separation with both MP461 and MP495 According to the position of the MP495, the departure clearance sent to TAP 120 was to turn right, climb upper than FL 060 and then come back overhead the airport on the way to Lisboa
07:18:42	FL 070	СРТ	ja	Sound altitude alert and selector knob. Means the aircraft is approaching FL 070
07:18:50		ATC	The wind 2, sorry 150 at 24 knots, cleared take off runway 11,right turn to be overhead above 60	Take off clearance for TAP 120 Note the value of the wind speed
07:18:52		CPT		Unreadable
07:18:54		F/E	What ?	
07:18:55		CPT		Unreadable
07:18:56		F/E	OK, I'll check that	
07:19:09		ATC	MP495, descent 4000 to be below 60 at least at 10 DME	
07:19:15		MP495	495 roger, below 60 10 DME down 4000 feet	
07:19:19		F/O	4000 feet armed	
07:19:20		CPT	OK	
07:19:26		CPT	report out of 60, 10 DME	
07:20:03		F/O	Approaching 60	
07:20:05		CPT	ja	
07:20:07	FL 060	MP495	495 is Out of 60	
07:20:11		ATC	495 roger next report passing overhead joining outbound radial 269 for further clearance	
07:20:19		MP495	Wilco, MP495	
07:20:37		MP461	MP461 is at 2000 feet to maintain, we approaching 7 miles out and we are turning inbound shortly	
07:20:47		ATC	461, copied, newt report leaving 2000 feet 7 miles inbound	
07:20:48				Sound of altitude alert (approaching probable 4000 feet)
07:20:52		MP461	l will do, 461	
07:21:02		F/O	Altitude capture	The flight reaches 4000 feet
07:21:04		CPT	Check	

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07:21:21	4000	MP495	MP 495 maintaining 4000	
07:21:23		F/O	Altitude hold	
07:21:25		ATC	495 confirm distance	
07:21:27		MP495	11	
07:21:29		ATC	Roger next report overhead	
07:21:33		MP495	495, wilco	
07:22:50		F/O	Slats take off	
07:23:02		CPT	Slats are take off	
07:23:25		MP461	MP461 is leaving 2000	
07:23:29		ATC	Confirm runway in sight	
07:23:29		F/O	Flaps 15	
07:23:32		MP461	Negative, fully IMC	
07:23:35		ATC	Roger, request at minimums or runway lights in sight	This can indicate that the ATC controller would not be surprise if the traffic MP461 must perform a missed approach
07:23:41		MP461	Call you	
07:23:44		ATC	MP495, when passing overhead, join outbound radial 269, initially descent to 3000	The ATC controller wants to maintain at least 1000 feet of vertical separation with the MP461
07:23:53		MP495	When overhead at 269 radial and down 3000	
07:24:02		CPT	Yes over here, you can see the runway	
07:24:04		F/O	ja	
07:24:06		MP461	MP461 runway visual	Meaning that the MP461 got the runway insight at about 1700 feet above ground level
07:24:09		ATC	Cleared to land runway 11, runway surface conditions flooded, wind 150 20 knots	
07:24:16		CPT	Flaps are on 15	
07:24:18		MP 461	150 20 MP461	
07:24:36		F/O	Ik heb VOR geselectoerd	
07:24:38		CPT	That's right, me too	
07:24:50		CPT	There is the 767	they can see the MP461, meaning then they are out of the clouds at this moment
07:24:51		F/O	Ja altitude capture	They reach 4000
07:24:56		F/O	3000 feet is armed	
07:25:00		CPT	Check	
07:25:11	4000	MP 495	495 is overhead leaving 4000 for 3000	
07:25:19		ATC	495 roger, confirm VOR:DME procedure runway 11, continue descent to 2000 feet, report turning inbound	
07:25:26		MP495	Call you turning inbound and proceeding to 2000 feet	
07:25:30		F/O	2000 feet armed	
07:25:35		MP461	MP461 final	

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07:25:41		ATC	Cleared to land now 130, 18, 20 maximum	
07:25:46		F/O	Flaps 22	
07:25:54		CPT	Flaps are 22	
07:25:59		CPT	You may turn at 8 DME	According the Jeppesen chart (valid NOV 91), this is the normal procedure. The point at 10 DME is the end of the outbound holding pattern.
07:26:01		F/O	ja	
07:26:16		F/O	Heading select	
07:26:18		F/O	2500 QNH set	
07:26:33		F/O	Altitude capture	
07:26:35		CPT	Check	
07:26:44		F/O	Altitude hold	
07:26:45		CPT	ja	
07:27:53		CPT	Approaching 8 miles	
07:27:54		F/O	ja	
07:27:56		CPT	I'll give you one one one	The CPT changes the radial 269 to 111 in the VOR window
07:28:01		F/O	Overhead, heading zero eight zero	They are at 8 DME and the F/O calls out his own action to turn right towards interception heading of 080°
07:28:11		CPT	495, is turning inbound	
07:28:17		ATC	495 copied, report at minimums or runway insight runway surface conditions are flooded	
07:28:26		CPT	Roger, call you	The delay between the question and the answer (9 seconds) is important
07:28:55		CPT	Seven DME	The captain reminds that the beginning of the descent is at 7 DME
07:28:57		F/O	Yes, then the gear may be selected down	The anticipation is correct. A few seconds before the beginning of the descent, the gear must be selected down.
07:29:00		CPT	Gear down	According to the standard procedure, this is the F/O who is supposed to ask for this item
07:29:17		CPT	The wind is from the right	
07:29:22		CPT	Gear is down	
07:29:23		F/O	Yes thank you	
07:29:25		F/O	Flaps 35	
07:29:28		CPT	Flaps 35	
07:29:32		CPT	Flaps are 35	
07:29:36	2000	F/O	Vertical speed selected	This action is directly performed by acting on the cursor. This is the effective beginning of the final descent
07:29:43		F/O	Flaps 50	
07:29: 50		CPT	Flaps 50	

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07:30:00	CPT	Six DME seventeen thirty	The captain checks the crossing of the 6 DME window to facilitate the monitoring of the slope. The Vz is more or less around 700 ft/mn i.e. 70 ft in 10 seconds. Time to descent from 2000 ft to 1730 ft is 38 seconds. Means that 1730 should be cross at 07:29:55. The path is a little higher than normal (around 40 ft)
07:30:05	CPT	Check ?	The F/O did not answer to the Captain's remark The CPT insists to bring back the F/O into the procedure
07:30:06	F/O	Yes, check	
07:30:08	СРТ	Five DME, fourteen fifty	This is an anticipation Normally, the crossing of the 5 DME window should occur at 07:30:33
07:30:13	CPT	Wind is coming from the right, 30 knots, drift is 12° so you make it one two three or so	The correction is correct and there is no indication that the flight is left of track, otherwise the captain would ask for a greater heading to correct the flight path.
07:30:22	F/O	ja	
07:30:25	F/E	OK for the landing check list	The F/E is aware of the workload of the pilots and try to perform this last check-list at the best moment regarding this workload
07:30:27	F/O	Ja, landing check-list	

07:30:28	≈1450	CPT	Four DME, eleven twenty	The check at 5 DME seems to be satisfactory because there is no comment about the position on the slope and the captain anticipates the next check. According to the previous check, the 4 DME window should be crossed at 07:31:05
07:30:32		F/E	Missed approach altitude	
07:30:36		CPT	three set	According to the Jeppesen procedure, the altitude of missed approach is 3000 feet on the east holding pattern
07:30:40		F/E	Altimeters	
07:30:41		CPT	Set three times	Means that the three altimeters are set on QNH and checked
07:30:44		F/E	spoilers	
07:30:45		CPT	armed	
07:30:46		F/E	I'll check them	Mean that the F/E is not fully satisfied and rearm the spoilers or can also indicates that he tells the captain that he will check the right extension of the speed brakes when on ground
07:30:47		CPT	Ja	
07:30:50		F/E	Flaps Slats	
07:30:52		CPT	50, land	
07:30:55		F/E	Landing check-list completed	
07:30:56		CPT	OK	
07:31:01	1180	F/O	The runway is	On some transcription, after this text the word "Flooded" is between brackets
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07:31:03	1150	CPT	Four DME, eleven twenty	The check is correct meaning that the aircraft is on the slope.
07:31:05		ATC	MP495, confirm inbound, how many miles	
07:31:08		MP495	We are 4 miles out	
07:31:14	1100	CPT	Yes, you can see the runway	Seems to be the answer to the F/O's question at 07:31:01 meaning that the visibility is around 3 miles (5000 m)
07:31:24		CPT	Three DME, eight twenty	Next window is at 3 DME and 820 ft normally at 07:31:41
07:31:29		CPT	Three DME eight twenty	The Captain indicates this information a second time because he did not got any answer from the F/O
07:31:33				The wipers are on
07:31:40	820	ATC	Confirm you have the runway in sight?	
07:31:43		CPT	Affirm	Classical question asked just before issuing the landing clearance
07:31:44		ATC	Cleared to land RWY 11 Wind 150°, 15 knots maximum 20	
07:31:52		CPT	Cleared to land	

07:31:53	560	F/O	Autopilot CWS	Indicates that the switching for CMD to CWS is done voluntarily by the F/O The flight is around 500 ft
07:31:54		CPT	OK, he, the runway is	
07:31:55		ATC	Confirm the lights are too bright ?	
07:31:58		CPT	No it's fine, keep it	The Captain confirm that the visual contact with the runway is good
07:32:00	500	F/E	(you missed) five hundred	The expression is into brackets meaning that the translator is not sure about this. This is the check to decide if the flight path is stabilized or not to continue the approach To be underlined: no answer from the captain. The level of stress seems to be high.
07:32:03		CPT	Cleared	
07:32:04		F/O	ja	
07:32:04		F/E	Ja checked cleared	
07:32:15		F/O	PAPI, hé	PAPI is in sight. There is no comment about the position on the slope. This could mean that that position is acceptable
07:32:16		CPT	ja	
07:32:20		CPT	Speed a bit low, a bit low	
07:32:24		CPT	Ja OK, speed is OK	The F/O makes a correction
07:32:29	400	F/O	Windshield, windshield anti-ice I don't see nothing-	This sentence is very important: 1/ the F/O makes a mistake: he asks for windshields instead of

				wipers; 2/ He loses the visual contact with the runway due to the rain; 3/ his level of stress is now very high.
07:32:30		CPT	ja	
07:32:32		F/E	You're at fast	The wipers was ON since 07:31:33. Either the F/E confirms that he cannot do anything because the wipers are already on Fast or he sets the wipers to Fast position
07:32:34	160	CPT	A bit low, a bit low, a bit low	This is the case since 07:31:29 The Captain urges the F/O to do something because he repeats the information three times. The gap seems to become significant. The level of stress is very high.
07:32:36		F/O	ja	
07:32:37		CPT	OK, OK, OK	
07:32:39		CPT	Wind is one ninety with twenty	The wind is fully from the right But we must consider this information as a wrong information regarding the use of rudder by the F/O
07:32:44	80			This double click sound should be the disengagement of the CWS mode.
07:32:47	50		RA audio signal	Crossing of 50 feet
07:32:48				Increase of thrust. The aircraft is not under control
07:32:49				Touchdown. Meaning that 50 ft was done is 2 seconds (~1500 ft/mn)
07:32:50	0			End of the record

8.6.5.3. DFDR ANALYSIS

The reference used by the Expert is extracted from the binder named "Lijst-2-map-3-sur-3".

The time reference of the NTSB analysis is a DFDR reference.

Consequently, a time coordination must be done to translate the conclusions.

The best coordination point is the touchdown point at 0007:02 DFDR elapsed time and 07:32:50 UTC according to the chart itself or 07:32:49 according to the CVR

The analysis of the DFDR shows two very different parts:

- From 07:31:00 to 07:31:32, the flight path is quite calm:
 - The CAS around 145 kt
 - The acceleration around 1G and
 - The N1 around 75% with one deviation to 80 %
- After 07:31:32, the instability is obvious:
 - the control forces and the position of the control column;
 - o the lower and upper rudder and the roll angle;
 - o the aileron between 10° right wing down and 5° left wing down;
 - the acceleration begins to flicker between 0,8 and + 1,25 to reach 1,95, 1 second before touchdown;
 - o the CAS between 154 and 141 kt;
 - the thrust (N1) between 63 and 102 % before be reduced to flight idle at 07:32:45, 5 seconds before touchdown;
 - the pitch attitude usually around 4° with the flaps 50° on a 5% slope fluctuating between 0 and 9,5 °at touchdown;
 - o extension of the spoiler (roll assistance) mainly to the right hand side.



8.6.5.3.1. THE VERTICAL ACCELERATIONS

Vertical acceleration

To analyze the actual acceleration, the aircraft, sustain during this final approach, we must take into account the instantaneous bank angle because this angle creates a centrifugal force.

For instance, for a bank angle of 10°, the G force will be 1.0155 and for a bank angle of 60°, this G force will be 2 G meaning your weight will be twice your normal weight.

Considering the fact that, on most cases, the bank angle fluctuates between + or - 5°, the applicable correction is small and equivalent to a 1,004 G (400 grams for 100 kilograms)

According to an obsolete ICAO turbulence scale, the classification is the following:

• Very low: below 0,05 G

Yaw and roll oscillations

- Low: 0,05 to 0,2 G
 - bumps and oscillations but without significant changes in altitude or attitude
- Moderate: 0,2 to 0,5 G

Strong, intermittent uncomfortable jolts with attitude upsets and indicated airspeeds variations

• Severe: 0,5 to 1,5 G

Aircraft handling in all axes is made difficult but not dangerous except at lower altitudes

Very severe: above 1,5 G Extreme handling difficulties, aircraft may be out of

controls for short periods, structural damage is possible.

This classification is not any more in use because each aircraft, according to its physical characteristics, would have specific responses to the turbulence.

Nevertheless, the Experts should consider that, even light and occasionally moderate as indicated in the crew's and passengers' statements, the turbulence was effective from 07:31:40 UTC to the end of the flight.





8.6.5.3.2.1. THE RUDDER.¹⁴⁹

¹⁴⁹ It is internationally agreed that the "negative" sign is applied to the movements or values towards the left.

When the autopilot is engaged, the rudder actuators are enslaved to the yaw damper computer.

The actions of the Yaw damper actuator on the rudder are limited to + or -5° . On all operating modes, except AUTOLAND¹⁵⁰, the pilot does not feel the rudder movements.

That means that until 07:31:56 UTC, the recorded rudder movements are only the consequence of yaw damper orders.

When the autopilot operating mode changes from CMD to CWS at 07:31:56 UTC, the rudder actuators receive the signals both from the pedals and from the yaw damper computer. The movement of the inner rudders are limited to $+ \text{ or } - 23^{\circ}$.

This means, that after 07:31:56 UTC, the rudder movements are the consequence of both the pilot's actions and the yaw computer.

The rudder movements are quite important but it is not possible to qualify them as abnormal according the weather conditions (thunderstorm, wind rotation and rain).

Below 150 feet (radio-altimeter), the rudder movements are, most of the time, towards the left, (add to actions on the same direction with ailerons) inducing a quite important bank angle of 15° to the left, this value being out of the limit for the landing.

We must take into account the fact that, below 150 ft, the pilot must also « align » the aircraft with the runway and de-crab the flight path in case of drift.

This is the case for the MP495.

Technically speaking, the DC10 is designed to perform this task automatically in case of automatic landing, using the autopilot AUTOLAND mode.

For this approach, this configuration is not implemented for two reasons:

- The approach is not an ILS approach but a VOR-DME one
- The crosswind is out of the limit for an automatic landing.

In case of landing with crosswind, three technics are available:

- Landing with the drift angle and align the aircraft after the touchdown using the flight controls and the friction;
- Sideslip landing: de-crab the plane quite early and then fly the center line managing the bank angle;
- De-crab the plane just before the touchdown with the rudder and the aileron to maintain the aircraft levelled.

The DC10 « does not like » (as the pilots said it) the first technic, not because it is not possible to perform it, but because it is very uncomfortable for the passengers. At the opposite, for instance, the Boeing 747 « accepts » this technic without any problem.

¹⁵⁰ After the pre-land test allowing, if positive, the autopilot to take the control of the three flight controls.

The autopilot of the aircraft is design to use the second technic, beginning the decrab at 138 ft and managing the center line with the aileron (bank angle). The feeling for the passengers is not comfortable because the plane fly all along the approach with a bank angle.

Generally speaking, the pilots land the aircraft using the third technic because during the approach, the flight is symmetrical. The touchdown is also more comfortable for the passengers... if the pilot's technic to flare the aircraft is good!

The F/O's actions on the rudder could match with the second technic but the question was not raised by the Commission of investigation during the interviews.

8.6.5.3.2.2. THE AILERONS

The control wheel is linked at the same time to the ailerons actuators and to the spoilers actuators via a spoiler mixer: the spoilers provide an assistance to the aileron in order to have an efficient control of the bank angle.

The functioning law is the following:

- Each aileron surfaces can move between + 20° and 20° depending of the position of the control wheel;
- The spoilers are activated when the ailerons are at more than 10° and will reach 60° when the control wheel is at 90°;
- For a movement of the ailerons of 5°, the pilot must apply a displacement of the control wheel of 22.5 °.

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On a DFDR record, the movement of ailerons is not immediately significant to a casual observer because, as we have seen above, it is highly under-fold relative to the movement of the control wheel.

On the curve above, the movement of the control wheel is reproduced as an indication because the values displayed are not measured but calculated.

Until 7:31:56 UTC, the autopilot controls the aircraft and more specifically, the ailerons.

It is important to note the movements of the control wheel around 7:31:40 UTC and around 7:31:53 UTC because these movements are the result of an action of the autopilot.

These actions show that an external and relative instability area is crossed.

The Captain in his statement did not underline this instability, showing us that it could be consider as not abnormal.

After the disengagement of the autopilot and the activation of the CWS mode, after 07:31:56 UTC, the movements of the ailerons are much more important and they are increasing in amplitude. The Experts note that the actions are mostly oriented to the left.

At low altitude, the pilot's actions become very strong and very unstable.

It is also possible to emphasize the concomitance between the actions on the ailerons (almost 60° to the left on the control wheel) – the bank angle reaching at this point 15° to the left – and the actions on the rudder in the same direction.

8.6.5.3.2.3. CONCLUSION

This analysis suggests:

- That a relatively strong instability is obvious below 400 feet above the ground;
- That the pilot was very active on the controls with relatively large inputs on the rudder;
- That the bank angle in very short final seems to be the result of the simultaneous action of the ailerons and the rudder, both due to pilot's inputs.

According to the third point above one might conclude that the pilot, and only the pilot, is the source of destabilization.

This is not what the Experts say. It is possible that destabilization was felt by the crew and induced the F/O's reaction on the controls.

8.7. ANALYSIS OF THE DOCUMENT "LIJST 2 NR. 5 : DE TEKST VAN DE VOORLICHTINGSBIJEENKOMST VAN 1 DECEMBER 1994 (PRODUCTIE 5 VAN DE DAGVAARDING)"

This document is the literal transcript of the information meeting of the Civil Aviation Board for the victims and families of the Faro air disaster.

Name	Functions	
Mr LOEB	Chairman of the meeting	
Mr GROEN	Meteorologist	
Mr BODEWES	Chairman of the Civil Aviation Board	
Mr SNOEK	Pilot - Civil Aviation Board	
Mr HOFSTRA	Pilot - Civil Aviation Board	
Mr BARENDRECHT	Pilot - Civil Aviation Board	
Mrs VAN BEEK	Institute Essenburg	
Mr SÖTEMANN		
Mr WESTERMAN		
Mrs VAN VEEN		
Mr VAN DER ELST		
Mr WINKELMAN	Passengers' families or representatives	
Mr SCHOTGERRITS		
Mr JASPERS		
Mr SCHOUTEN		
Mr BATENBURG		

The different persons and their quality:

The Experts note that the Chairman indicates clearly the limits of this information meeting inside the ICAO annex 13: no culpability, no liability, no financial issues.

It is important to consider that this position is the golden rule of the Dutch Aviation Safety Board's behavior.

During this meeting, it appears that the Claimants consider that the testimonies of the passengers were not taken into consideration.¹⁵¹ and that the persons in charge to provide explanations have not explained the process of an investigation, which would have probably responded to the questions.

During an investigation, all information is important and no information prevails over another. Specific information opens for questions that the Commission of Investigation will keep open or will close, according to the elements at their disposal.

¹⁵¹ Refer to meeting minutes BVO/92/12/75 (lijst 4 nr 9) : « The passengers statement (translated) will be presented to the Portuguese Authorities supplemented by the questionnaires completed on the basis of the statement »

Thus, some passengers stated to have seen the right engine on fire, before the contact with the ground.

But the flight recorders, either the DFDR or the CVR, show no signal matching with this situation. Indeed, an engine fire shall undoubtedly be recorded and the aural warning in the cockpit as well.

Moreover, other statements indicate that there was no fire on this engine.

In the absence of objective confirmation, the Commission of Investigation closed this issue.

It is the same with the altitude loss attested by a passenger which saw the information on the screen providing the position of the aircraft in cabin during the flight.

No record confirms the words of the passenger and the Commission of Investigation therefore closed this issue.

Other testimonies cannot be taken into consideration.

For example, the testimony of the passenger indicating that the aircraft gained altitude because "*at some stage, we were above the cloud cover*" cannot be taken into account. Indeed, what the passenger saw is probably true: but his (or her) deductions are false, because a cloud layer is never horizontal or linear, especially in the event of instability.

What another passenger calls for a go-around "*until we were above the cloud cover*" is perhaps the strong correction recorded during the last turn before the final approach. The Experts have no time reference indicating when this passenger felt this increase of thrust. But the description matches to what can be felt when entering a cloud with a downburst: a thrust correction, may be important, is made just to maintain the altitude and then, you get out of this cloud.

The feelings match with a climb but nothing like this has happened or is recorded. Here we are in a well-known case for the pilots: the sensory illusions. And the first law to avoid the dangerous consequences of it is: "Trust your instruments at all time!"

A little bit later, the questions become more technical but the answers are sometime not appropriate.

The reader will refer usefully to paragraph 8.6.3.1 of this report for more details.

Again a little bit later, no explanation is provided to the fact that the CVR stops functioning at the time of impact.

To explain it, it would have been useful to explain the technology used at this time. The system consisted in a tape-recorder, operating with a continuous tape of 30 minutes, meaning that it was only possible to record the last 30 minutes of a flight. In case of strong impact, the recording head can hit the tape because of the G-forces, and the record is then lost.

8.8. THE 143 QUESTIONS, THE ANSWERS AND THE EXPERTS' COMMENTS

Refer to Judgment of 26^{th} February 2014 § 3.10 for details.

Convention to understand the remarks raised by the Experts:

No comment:	means no more comment that the one provided by the Dutch Aviation Safety Board;
Not applicable: Not in our scope:	means does not be linked to the case; means out of the questions raised by the Court to the Experts.

Question raised by the families Answers from the Aviation Safety Board or by Martinair	Dutch	Remarks b applicable	by the	Experts	if
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About the interviews of the pas National Police Force]	sengers by the Aviation Service	[Dienst Luchtvaart - part of the
 Is the official Portuguese commission of inquiry aware of that fact that all passengers who want this will be interviewed by the team of detectives of the Aviation Service? 	In summary, all the passengers were interviewed who wanted to be. Their statements, translated into English, were given to the Portuguese commission of inquiry. The information from the statements had been included	Yes. Refer to the meeting minutes BVO/92/12/75 (lijst 4 nr 9) : « The passengers statement (translated) will be presented to the Portuguese Authorities supplemented by the questionnaires completed on the basis of the statement »
Portuguese Commission of inquiry of the opinion that all reports should be translated into English so that they too will be able to read the contents?	in the final report, specifically in the "Survival Factors" section.	
3. Even if that is not the case, I am of the opinion that Minister Weggen should be asked to instruct the Dutch Preliminary Investigation committee to have all statements by passengers translated into English and made available to the official Portuguese Commission of inquiry.		Not applicable

About the state of maintenance of the Anthony Ruys					
4. Is Martinair prepared to	Yes, Martinair is prepared to	The technical story of an aircraft			
provide a list of all faults and all	give the competent authorities	is at all time followed in detail			
maintenance operations during	and bodies access to faults,	by the specialists.			
the past year and a half to the	maintenance and repairs to the				
aircraft, stating the repairs	aircraft concerned, (in so far as	As indicated, the aircraft was			
made; including special	this has not already been	"good for fly" except for the			
maintenance just before take-	done).	reverser n°2 (approved			
off?	-	technical deviation)			

About the delay of the disaster flight by 35 minutes at Schiphol					
5. If not, then can such a list be demanded.	Not applicable	Not applicable			
6. What was the true reason for the delay of the disaster flight by 33 minutes at Schiphol?	Repairing a reverse complaint to the tail engine (engine no. 2).	Not applicable			
7. What is Martinair trying to cover up by stating that it only concerned catering and check in problems while the captain informed the passengers that: "The crew are ready to take off, but the technical people had not yet finished"?	Martinair is hiding something. It is a normal occurrence that shortly before a take-off many people of different departments, including the engineering department, catering, passenger service [translator's note: "passagedienst " unclear] and apron department are busy in and around the aircraft.	It is rather frequent that the person performing the announcement is not aware of the actual reason of the delay. Of course the Captain knew the actual cause of the delay and there is no reason to hide it to the passengers.			
8. Is it permitted that passengers board before all technical problems have been solved?	Yes, that is permitted.	It is a Captain's decision, done in coordination with the ground staff, regarding the technical problem to be solved.			

About the left-hand engine						
9. What was the reason that there was an elevating work platform by the left-hand engine, as a number of passengers observed just before we boarded.	There was no elevating work platform at the left-hand engine but there was one by the tail engine.	Nevertheless, it could be a routine operation as the maintenance is not only performed inside a specific shelter but can also be performed as we said it "on line". This is called "Continuous airworthiness"				

10. Were there technical problems with the left-hand engine before departure?	No.	Not reported on the maintenance log book if we refer to the Portuguese Official report.
11. If so, why was it not decided to do a "test take-off" [translator's note: or possibly "test start"] before departing?	Not applicable.	These "test take-off" or "test start" are performed after specific maintenance actions. These actions are defined in a maintenance protocol certified by the certification authorities, in this case the FAA and the Dutch ones. No test start or "test take off" was needed in this case.
12. Can it be determined from the black box data or remains of the left-hand engine if this might have suffered problems from take-off?	n From the data of the Digital S Flight Data Recorder (DFDR) it may be concluded that the left- s hand engine, and the centre engine and the right-hand engine operated normally from take-off through to the time of the accident.	Yes, it can. The "Black boxes" are also used by the maintenance for technical follow-up such as engine performance at takeoff for instance.

About problems during a flight on 3 January 1992				
13. Was the Martinair aircraft which last year in 3 January, in the morning, left Schiphol with 3 ½ hours' delay after a "test take-off" the Anthony Ruys?	No.	No comment		
14. Was the aircraft which on 3 January 1992 at 4 in the afternoon could not depart from Faro but first had to be repaired on site the Anthony Ruys?	Yes.	The aircraft performed a lot of flight and a lot of maintenance actions between the two days.		
15. In case both aircraft are the same aircraft (even if it is not the Anthony Ruys) was it now after the fact not clear that a trial take-off was in fact insufficient and that in fact a replacement aircraft should have been chosen as the repaired aircraft should have been subjected to a "test flight" rather than a "test take-off"?	There are strict regulations, imposed by the authorities and supplemented by company regulations, which clearly describe how a complaint should be dealt with and if a test start or test flight is required. In the present case neither a test take-off nor a test flight were required at all.	No comment		

About the busy Christmas period		
16. Did a rush to drop our charter flight in Faro in the busy Christmas period lead to not choosing greater certainty through a test take-off or complete certainty by using a different aircraft.	No, there was no rush at all.	For the crew, there is no rush period. There is only flight safety. The only question is : "Is my aircraft able to safely fly or not?"

About the weather		
17. Was it responsible to land in the weather conditions at Faro?	It was responsible to land under the weather conditions which the crew were informed of.	Yes it was responsible to continue the approach.
18. Did the crew have sufficient information to judge if a landing with a DC10 was responsible with 100% certainty?	With the weather conditions which the crew were informed of they had enough information to decide whether or not the landing was responsible. The rapidly changing weather conditions during the last stage of the flight were not known to the crew. Hence these conditions could not be included in the decision-making about the landing.	100 % certainty does not exist. The target is to minimize the risk as much as possible.
19. According to several newspapers, at 06.00 hours GMT (7 hours Dutch time) the Portuguese aviation authorities gave a special warning for hazardous weather conditions with heavy thunderstorms and heavy icing. Did the warning from Portugal at 06.00 GMT reach the crew of the Anthony Ruys?	The Portuguese authorities did indeed issue such a warning. The correct text is included in the report. This warning was not communicated to the crew of flight 495.	Yes, according to the Official report, a SIGMET number 1, valid between 06:00 and 12:00 UTC was issued warning for Clear air turbulence conditions but above the flight level 340 (34.000 feet or 10.360 meters)
20. Is it true that before the Martinair aircraft, other aircraft diverted to Sevilla?	That morning, before the Martinair aircraft, no aircraft diverted, according to the statement by the Portuguese	No
21. If so, was that because Faro airport was temporarily closed due to bad weather?	authorities.	Not applicable
22. If so, what was the observable improvement in the weather as a result of which the Martinair aircraft did get permission to land?		

 23. If other aircraft did divert, but the airport was not closed, then was the decision to continue flying a personal decision of the crew of these aircraft? 24. If so, what types of aircraft did this concern? 25. Could the crews of these aircraft be asked what their reasons were and if these had to do with the weather 		
26. Did the Anthony Ruys crew, during the last contact	The Anthony Ruys received the latest weather information from	It is an international procedure. The ATC controller (ATCO)
with the control tower, receive specific information about the weather and what was that?	the traffic control tower, one minute before the accident. This was: "The wind 150, 15 knots, maximum 20".	giving the landing clearance/ authorization give also the last wind conditions. But in our case, these conditions were the runway 29 conditions and not the runway 11. The crew could not know that the information provided is not correct.
27. Was it stated, as it appeared in some messages in the press, that there was still 1/8 thunder cloud on the horizon?	This was not indicated at the time.	About the meaning of such an information, 1/8 thunder cloud does not mean anything according to the standard phraseology. Let us understand that the question is about "1/8 cumulonimbus". 1/8 is the portion of sky covered by the cloud, meaning that 7/8 are free of clouds
28. If so, could it have been known to the crew that it is risky to land in that, as downdraughts (microbursts) just above the ground can occur in that?	See the answer to question 27.	No comment.
29. In that case, what made the crew decide to start the landing despite that?	The last weather information received confirmed the picture the crew had formed of the weather and did not impede the landing.	Not applicable . <u>Comment</u> : The question is not to begin an approach but to continue it, depending on the actual conditions.
30. Might there have been economic motives at stake, as suggested by spokesperson Gielen of Alltalla suggested	Definitely not.	The economic motives never take the lead on the safety motives.

in Nieuwe Revu [translator's note: Dutch magazine] of 27 January?	
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About possible overconfidence by the crew		
31. Are there any statements on the tapes of the Cockpit Voice Recorder which could suggest overconfident or irresponsible action on the side of the crew?	Such statements are not included on the tape (see transcript).	No.
32. Why did the pilot inform the passengers several minutes before the crash that the wind was UNFORTUNATELY from the east during the landing?	With respect to this question Capt. Van Staveren stated that he could not remember saying something like that on the Public Address System. * However, had he said something like that then it would have been with the idea that the weather would probably stay like that for the first days and that as a result our passengers would not have the best possible holiday weather. Furthermore, this statement would have been made during the standard speech which is always made well over half an hour before arrive and certainly not a few minutes before the landing.	No comment.
33. Why did the pilot tell the passengers, less than one minute before the landing "Ladies and gentlemen, now we are really going to start the landing: We are ready for it."?	The pilot can state with certainty that less than one minute before the landing no statements were made over the Public Address System.	Not applicable. <u>Comment</u> : one minute before the landing, the high workload of Crew does not allow to make any announcement.

About unsteady approach		
34. Why does Martinair persists that until the time of the downdraught the flight was "completely normal" while almost all passengers testified that the pilot had the greatest possible difficulty controlling the aircraft during the landing procedure?	It will undoubtedly have been turbulent during the final approach. This is also indicated by the record of the flight recorder. This will have made it more difficult to control the aircraft, but it was not exceptional. The link which you make in your question between the turbulence the passengers experienced and "the pilot had	According to the CVR and to the DFDR, the flight was completely normal till the beginning of instability below 700 feet.

	the greatest possible difficulty controlling the aircraft" is your responsibility and I cannot support it.	
35. Is the commission of inquiry aware of the fact that at least one member of the crew stated never to have had such an unsteady approach in her career?	None of the crew said something like that in their statements.	No comment.
36. Is the commission of inquiry aware of the fact that at least one member of the crew stated that they had been afraid the whole trip?		
37. Is there anything to be found in the interviews of the crew about these statements by the passengers?		

About what happened at 2 minutes before the scheduled landing time. Around 7 minutes before the actual landing.		
38. What happened exactly 2 minutes before the scheduled landing time, around 7 minutes before the crash, when the aircraft was suddenly pulled up from 1170 to 1226 ft with roaring engines?	Answer BVO	The aircraft crossed a turbulent area.

About an unusual approach route:		
39. Is it true that the Anthony Ruys flew over Almanville while one would normally fly over Villamoura, 20 km away?	Answer BVO	It is the normal work of the ATC-system to provide more direct routes ("Direct to", Radar vectors, etc.).
40. If so, what was the reason for that diversion?	Answer BVO	Not applicable

About the use of alcohol or drugs		
41. Is there in Portugal, as in the United States, a statutory duty to test drivers on the use of alcohol and drugs in the event of serious traffic accidents?	Answer BVO	Yes It is a ICAO standard and recommended practices.
42. Was the Anthony Ruys crew	Answer BVO	No information.

tested on the use of alcohol and drugs, immediately after the accident?		
43. If so, what was the outcome of these tests?	Answer BVO	Not applicable
44. If tests were not undertaken, would that not amount to serious negligence by the authorities given the seriousness of the accident?	Answer BVO	No comment

About air traffic control		
45. Is it true, as claimed by Diáro de Sul, that the air traffic controller observed flames at the Anthony Ruys at 7.26 km from the airport at an altitude of 400 to 500 meters?	Answer BVO	No
46. If so, why did the air traffic controller not report that to the crew?	Answer BVO	Not applicable

About fire in the right-hand engine before the landing			
47. Did the crew of the Anthony Ruys state to the detectives of the Aviation Service that the right-hand engine was on fire before we touched the ground?	No, the crew stated that the right-hand engine was not on fire.	Not applicable Comment : for a one hand, there is no warning on the records and for the other hand, witnesses' statements are available indicating that there is no fire.	
48. Was the crew of the Martinair Boeing which landed slightly earlier also interviewed by the detectives?	Answer BVO	Yes	
49. Did captain Charbon of the Boeing confirm to the detectives that before the landing he heard one of the Anthony Ruys shout "Shit, we are on fire"?	No, definitely not.	No	
50. Did Charbon see fire by the right-hand wing before the Anthony Ruys touched the runway?	No.	No	

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51. Is the commission of inquiry aware of the statements by passengers who saw that the right-hand engine was already on fire before the Anthony Ruys touched the ground?	Answer BVO	The statements have been delivered to the Commission of Investigation.
52. Was a signal received in the cockpit that the right-hand engine was already on fire approximately 1 minute before the aircraft crashed?	Answer BVO	No fire signal recorded neither on the DFDR nor on the CVR
53. If not, then is the aircraft manufacturer not responsible for the lack of such a signal?	Not applicable	Not applicable.

About the true cause of the crash			
54. Given the fact that the right- hand engine was already on fire before the landing and the possibility that the left-hand engine was faulty, was the weather actually an essential factor, or did we simply crash and were we lucky that this happened so close to the ground?	Answer BVO	Not applicable.	
55. Is a potential fault of the engines the responsibility of the engine manufacturer or the maintenance company, in this case KLM?	Not applicable	Not applicable.	

About the fire brigade		
56. How can it be explained that the fire brigade were immediately present on site and covered passengers, who had left the aircraft within one minute of the crash, with foam?	During every take-off and landing an emergency team is standing by in a truck with the engine running. During the landing of the DC-10 there was no fire engine on the runway. The aircraft crashed on the south side of the runway, almost opposite the fire station and that is the reason why they needed	No comment.

	so little time to reach the aircraft.	
57. Had the fire brigade been warned that an aircraft was experiencing problems or did the fire brigade have reasons based on their own observations (noise, fire) to be ready to get going?	No see answer to question 56	No comment.

About the place where the Anthony Ruys hist	
58. Why did the aircraft not land in the center of the 120 meter- wide runway but at 10 meters from the edge?	A runway is 45 meter-wide. Understanding why the aircraft land on the left-hand side of the runway is the beginning of the whole explanation of the accident.

In the length		
59. Is the length of the braking distance of a fully-loaded DC10 in accordance with the place where the aircraft first touched the runway?	Yes, the length is more than adequate. During the approach the aircraft was on a correct glide path to touch down at such a distance from the runway threshold that there would be enough distance for a safe stop.	Yes

About the safety of the passengers on the aircraft			
60. Which of the following matters are the responsibility of the airline, which of the maintenance company and which are the responsibility of the aircraft manufacturer?	Answers from question 61.	No comment	
61. Did seats detach in areas where this should not have happened?	Answer BVO	No comment	
62. What forces are the seatbelts of the passengers calculated [designed] for?	The forces are calculated for 9G of forward speed.	No comment	
63. In what condition were the seatbelts on the Anthony Ruys?	Answer BVO	It is an item checked before each flight to know if whether or not the seat is serviceable.	
64. Were several seatbelts, whether they had come	Answer BVO	No comment	

loose or not, in a ragged condition?		
65. How is it possible that installation errors were made, so that at least two seatbelts were installed the wrong way round?	There cannot be installation errors. The hook-in-eye principle means that incorrect installation is impossible.	No comment
66. Why are there only waist seat belts for little kids on laps, without shoulder straps, like on any car seatbelt for babies?	There are no baby seatbelts with shoulder straps as the baby seatbelt is connected to the seatbelt of the passenger who has the baby on their lap.	No comment
67. Could airlines be required to have baby seatbelts with shoulder straps on board?	That could be done, but it is not required internationally.	No comment
68. How effectively should the hand luggage bins close?	The hand luggage bins should close properly. They are regularly inspected.	Item checked before each take off and each landing
69. Shouldn't they be centrally locked during the landing procedure?	No. They are checked by the cabin crew. Central locking is not possible.	No comment
70. What forces are the ceiling panels designed for and how flammable are they or the insulation material above them?	The fitting of the ceiling panels and the panels themselves meet the requirements set by the manufacturer and by the Dutch and American aviation authorities. The same applies to the insulation material above them.	Refer to international rules of certification.
71. What are the evacuation slides designed for? (Only for training or also for disasters?)	The slides are designed for use in emergency and precautionary landings (on the ground and on water) where stairs and/or bridges cannot be used.	No comment.
72. How extensively do the passengers have to be informed before the flight?	Thoroughly, in accordance with national and international regulations and rules.	No comment.
73. Would it not be useful to inform passengers of the possibility that it cannot only go wrong in the air and on the water but also on land?	See answer n°72	No comment.

Questions about the aftermath of the disaster. About the support of passengers who wanted to return by train. About the investigation of the cause of the disaster			
74. Should airlines not be required to provide effective medical, psychological and financial support for people who do not dare fly back with an aircraft after a crash?	Airlines will always do everything they can to provide help and support. A factor which should not be neglected is that experts often have to be transported across long distances. Furthermore, after the crash at Faro the runway was blocked as a result of which the experts could not get there quickly enough.	No comment.	
75. How in god's name is it possible that European airlines are still permitted to fly with insurance conditions for their passengers which date from 1966?	The regulations are set internationally.	No comment.	
76. To what extent is Dutch politics responsible for the fact that since 1966 the road traffic act has increased the mandatory insurance from approximately 250,000 guilders per event to at least 2,000,000 guilders while for aviation it is permitted to fly while the airline has only insured their passengers for non-indexed amounts from 1966 in devalued dollars.	This is outside our competence.	No comment.	
77. Does Martinair also have insurance for the aircraft for an amount for which a similar aircraft could be built in 1966?	The purchase price of aircraft over a period of 27 years, as referred to, and the review of the existing conditions, are two unconnected matters. Both have been increased significantly	No comment.	
78. Is Martinair - in so far as they are culpable and not the Faro air traffic control or the manufacturer of the DC10 – prepared to provide compensation to those seriously affected, from their own resources, similar to the regulations which apply, for example, to car insurance?	Not applicable.	No comment.	
79. If not, then can Martinair be	Not applicable.	Not applicable.	

required to do so?		
80. If not, then can claims be addressed to the Dutch state?	Not applicable.	No applicable.
81. Is the information correct that all passengers who have indicated that they want to be interviewed will be interviewed the coming two weeks.	As far as we are aware, all the passengers who indicated they wanted to be have been interviewed.	The witnesses' statements have been sent to the Commission of Investigation. No comment about the delay.
82. Is the team of detectives of the Aviation Service not permanently understaffed in this period, especially if you realize that the same 6 detectives also have to deal with the aftermath of the Bijlmer disaster?	Answer BVO	No comment.

81. Is the information correct that all passengers who have indicated that they want to be interviewed will be interviewed the coming two weeks.	As far as we are aware, all the passengers who indicated they wanted to be have been interviewed.	The witnesses' statements have been sent to the Commission of Investigation. No comment about the delay.
82. Is the team of detectives of the Aviation Service not permanently understaffed in this period, especially if you realize that the same 6 detectives also have to deal with the aftermath of the Bijlmer disaster?	Answer BVO	No comment.
Questions from the letter about secondary and tertiary witnesses, addressed to lawyer Bunjes, mailed to lawyer Biemond on 15 March 1993		
83. Are four statements about fear responses from outsiders - who are very familiar with aircraft noise - enough to conclude that the passengers were not the only ones who	It is not up to Martinair to judge this.	No comment.

83. Are four statements about fear responses from outsiders - who are very familiar with aircraft noise - enough to conclude that the passengers were not the only ones who considered the engine noise of the Anthony Ruys worrying?	It is not up to Martinair to judge this.	No comment.
84. Why did the Anthony Ruys fly across the departures building when that is normally never done?	The normal instrument landing procedure at Faro requires flying across the airport, irrespective of the runway being used, before starting the landing. The word "never" as used in question is incorrect.	The arrival the day of the accident was performed using runway 11 because of the prevailing wind.
85. Could it be that the fire brigade, like those waiting in the [departures] building, were alarmed by the thundering noise of the aircraft passing overhead and because of that deployed more quickly than normally?	Answer BVO	No comment.
86. Can the passenger lists of the scheduled return flights from Faro on 21 December be	Answer BVO	No comment.

used to trace witnesses who may have made observations which are relevant to the investigation of the cause of the disaster?		
87. Did Mr. Charbon implicitly indicate in a discussion with a passenger of the 767 that the aircraft was indeed already on fire before the landing?	Νο	No comment.
88. If the thunderstorm was on the other side of the runway then can there actually have been a microburst on the side where the Anthony Ruys started the landing?	Answer BVO	It is rather impossible to anticipate the position of a microburst. This is exactly why such meteorological phenomena are dangerous
89. If there was a thunderstorm, even if it was on the other side of the runway, then was it responsible to land at that time?	Answer BVO	No comment.
90. Is it possible to interview witnesses in Portugal in general, who may have made observations which could shine light on the causes of the events?	Answer BVO	Witnesses' statements for workers or others are available.
91. Do observations about luggage bins popping open during other flights confirm the suspicion that the Anthony Ruys may have operated as a cargo aircraft for some time and then been converted back to a passenger aircraft?	In what configuration the aircraft flew or flies (passengers or cargo) is not relevant. The luggage bins are one separate part during the conversion. In other words, the bins do not consist of separate segments.	The aircraft involved was operated as convertible aircraft meaning it was built with passengers' windows and a cargo door. There is no relation between the two assertions.
92. Is it correct that a normal DC10 passenger aircraft, in addition to the two outer rows, has a double row of luggage racks in the center of the aircraft?	Martinair has a normal type of DC-10 which is available with and without luggage racks in the center.	It is a matter of commercial policy to fit the cabin with a center row of racks and not to be normal or abnormal.
93. Are/were the luggage racks on the sides of a DC10	An aircraft hand luggage can	Again it is a matter of
adequate for the luggage of 328 passengers?	be placed in the luggage bins and under the seats, for which purpose an additional bracket is fitted under the seats.	commercial policy.

the Netherlands as the owner of the aircraft due to endangering the passengers by allowing more passengers than the aircraft is designed for in terms of hand luggage space?		
90. Can airlines be required in future to choose between either providing hand luggage space in accordance with the design of the aircraft for passenger flights, or flying with a limited number of passengers?	No, the aircraft is certified for the number of passengers and the available space for hand luggage in the luggage bins and under the seats.	Not in our scope.
96. Between 9 and 21 December did Martinair have repairs made to the aircraft to fix the "perfectly normal" phenomenon that rubber feet of a video [equipment] bag melted due to the heat at the bottom of an aircraft?	A repair was indeed made to an air duct under the cabin floor, in front of the rear passenger door. A coupling in this air duct leaked and blew hot air against the floor.	No comment.
97. What was the matter on 17 December 1992 - four days before the Faro crash - with the Anthony Ruys that they had to fly circles over Cancun for an hour to use up kerosene before they could land?	There was nothing wrong with the Anthony Ruys on 15 December 1992 (and not 17 December 1992). Due to a favorable route the landing weight was slightly too high as a result of which the captain decided to fly in circles for around 15 minutes to reduce the landing weight by the lower quantity of fuel on board.	No information. <u>Comment</u> : This is a normal procedure as it is forbidden to dump fuel in such a case (not an emergency situation).
98. And why was the landing at that time so rough?	We have no information about a rough landing.	Not applicable to the case.
99. Was the stopover of an hour and a half in Miami only to bring fresh crew on board or was work done on the aircraft, and if so, what?	At Miami there was only a crew change.	Not applicable to the case. <u>Comment</u> : A stopover of less than 1 hour and half is not frequent for long range aircraft.
100. What was the reason that during the autumn holidays a mechanic flew to Tenerife?	He was going on holiday.	No comment.
101. Request for a list of all the maintenance on the Anthony Ruys during the past year and a half.	See the answer to question 4.	Already answered.

Questions from the letter about potential criminal matters, addressed to lawyer Toeter, mailed to lawyer Biemond on 25 May 1993.			
102. On 21 December 1992, did the Anthony Ruys leave Schiphol without permission of the technical maintenance department?	No, this aircraft was finished entirely in accordance with the rules and declared as technically airworthy by the Maintenance Department and checked as such by the crew.	Not applicable.	
103. How could this happen?	Not applicable.		
104. Why was the aircraft not recalled?	Not applicable.		
105. What is the reporting duty of technical personnel in case of such an incident?	There was no incident. An aircraft will not depart if it has not been released by the Maintenance Department.		
106. Was there actually an incident, or was it a "good" practice which developed over time that the pilots themselves determine whether an aircraft is airworthy or not?	There was neither an incident, nor a "good" practice which developed over time.	The pilots do not determine by themselves if the aircraft is airworthy or not. There are rules and procedures. The only cases for which a pilot can take the decision to take off with a defect are listed in a	
107. Did the pilot by departing in this way, act in accordance with written or unwritten instructions from the Martinair management?	Yes, fully.	certified document: the minimum equipment list.	
108. Are there standards and regulations for the minimum requirements which an aircraft has to meet after being converted from cargo aircraft back to passenger aircraft?	Yes, there are such regulations.	It is a certified process.	
109. Did Martinair comply with these standards?	Yes, fully.		
110. Is there an approvals body (e.g. the RDD) to issue a certificate of airworthiness every time an aircraft is converted to a passenger aircraft?	Martinair has authorised ground engineers who, in accordance with instructions approved by the RLD, declare the aircraft to be airworthy.		
111. Was such a certificate issued for the Anthony Ruys and if so, who is responsible for any shortcomings found later?	The aircraft was signed off in- line with the approved instructions and there were no shortcomings found later.		

112. Does Martinair have company regulations stating that the co-pilot is not permitted to land at a particular crosswind and if so, was the crosswind the crew were aware of above or below this standard?	Martinair does have such company regulations. The crosswind the crew were aware of was below this standard .	No comment.
113. Are there standards where it is a requirement to land a DC-10 manually and not with the autopilot in certain weather conditions and if so, were those standards exceeded in Faro?	Yes, there are such standards. They were not exceeded in Faro.	The flight crew operating manual indicates the cases in which landing using the autopilot is mandatory and also when it is forbidden to use the autopilot to perform a landing procedure. In our case, without an ILS (an ILS Cat2 is required to perform automatic landing), it is not possible to perform an automatic landing.
114. Is the conclusion justified that Boeing aircraft are generally easier to control than the DC10; and certainly under extreme weather conditions?	No.	No
 115. Is the conclusion justified that the Boeing 767, which landed at Faro just before the Anthony Ruys, is more agile and easier to manoeuvre the around 20 years old Anthony Ruys? A) Because it is a Boeing. B) Because it is a much more modern aircraft. 	No.	No
116. Is this also reflected in the landing limits for a Boeing 767 compared with a DC10?	No.	The cross-wind limitation is more or less the same on the two types.
117. Is it therefore explicable, on the basis of the above, that the Anthony Ruys crashed while the Boeing 767 did land "safely" with jolts and bumps, although one of those on that	No	Not applicable.

aircraft described the landing as "Sliding down the stairs on your ass."?		
118. Is the report still available on the basis of which the RLD made statements in 1970 about the unreliability of the cabin floor of the DC10 and is that report public?	That report was dealt with by the Federal Aviation Authority which issued an Airworthiness Directive note, under which all Douglas and Boeing aircraft had to be modified with decompression panels. These panels equalize the pressure above and below the floor.	Not applicable.
119. Was the floor of the Anthony Ruys ever modified to the standard which the FAA made mandatory after the crash at Paris in 1974.	Yes, the Anthony Ruys was modified to this standard.	Yes
120. How can it be explained that the floor section between rows 23 and 29 collapsed during the crash and took around 50 passengers with it, of whom at least 32 died?	Answer BVO	No comment.
121. Was the collapse of the floor in that area due to decompression?	Answer BVO	Νο
122. If not, then is it not strange that the floor collapsed in exactly the same place as during the Windsor incident of June 1972?	Answer BVO	No comment.
123. Can the collapse of the floor be attributed to the manufacturers?	Answer BVO	No comment.
124. Is it not necessary to reinforce the floor such that it simply cannot collapse due to decompression?	Answer BVO	Not applicable.
125. Would it not be advisable for the RLD to contact the Australian Air Transport Group which, according to our information, imposes and enforces much stricter standards than common in	Answer BVO	Not in our scope.

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the rest of the world? Apparently, the German RLD also uses much stricter standards than the Dutch ones.		
 126. Was there actually any chance of saving the fully loaded (weight 180 tons) Anthony Ruys after it had landed, given: A. The speed of over 260 km per hour; B. The place where it first touched the runway; C. The failure of all electricity, as a result of which it may not have been possible to engage the thrust reversers in the engines; D. The probable fire in the right-hand engine shortly before the landing. 	The aircraft did not weigh 180 tons but 161.4 tons. Given the question if there was any chance of saving the fully laden Anthony Ruys after it had landed the answer is unequivocally Yes, with respect to the statements under items A-C. There was no fire in the engine (item D).	A: yes. The brakes are designed for that; B: Yes. The aircraft landed exactly where it has to do it; C: Yes. The reversers are not electrically activated; D: not applicable
127. Can it be concluded from the black box and/or statements by the crew problems that there were problems with the landing gear and that it was attempted to deploy it several times?	Answer BVO	Not applicable.
128. Had the sudden climbing movement, already mentioned in question 34 (Sötemann question 38) from 1170 to 1225 feet approximately 7 minutes before the crash have anything to do with an attempted to get the landing gear "out".	Νο	Already answered.
129. Was the statement on 2 July 1993 by Mr. Schotgerrits a reason for the commission of inquiry to minutely examine the right-hand landing gear on any defects which may have been present before the crash?	Answer BVO	No comment.
130. If not, does the commission of inquiry see any reason for that now?	Answer BVO	
131. Or was it found in an earlier stage of the investigation what the cause	Answer BVO	Not applicable.

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was of the collapse of the right- hand landing gear?		
132. Was the collapse of the right-hand landing gear the result of a defect which existed earlier, or of an incorrect landing manoeuvre?	Answer BVO	No
133. Could the collapse of the right-hand landing gear be identified as the cause of the inability to control the aircraft during the landing and therefore as one of the main causes of the crash?	Answer BVO	Yes
134. Does the Hold Item list of the Anthony Ruys include any items which were not remedied which may be associated with the cause of the crash?	No, the Hold Item List did not include any items related to this crash.	No
135. Was a trip report made for the delay at Schiphol and if so, was the content of that public?	No, this would normally be written after the flight.	No comment.
136. If no trip report was written, then wouldn't the regulations have been infringed?	No, see the answer to question 135.	No comment.
137. What about the authority and experience of the Anthony Ruys cockpit crew to fly on a DC-10?	All were fully authorized and had more than enough experience to fly on a DC-10.	The crew was fully type rated and experienced to fly the aircraft.
138. Did the flight engineer, given that this was a Canadian agency worker, have adequate authority to stand up to the captain when he decided that the Anthony Ruys could depart from Schiphol?	Given the crew concept, each member of the crew, including the flight engineer, has their own specific competences and authority, irrespective of their nationality.	No comment.
139A. Does the Rijks Luchtvaart Dienst check the quality of hired-in cockpit crew of Dutch airlines?	Yes, the RLD checks each member of the crew.	No information.
139B. Would it not be useful to include the recommendation to the Raad voor de Luchtvaart in your report that the Dutch Aviation Act should state a maximum alcohol content with withdrawal of the licence to fly as a sanction for infringement?	Answer BVO	No comment.

140. At what point would the Anthony Ruys first have touched the runway had there not been a vertical downdraught which suddenly pushed the aircraft 50 meters down?	Answer BVO	At more or less 300 meters from the threshold.
141. Measured from that virtual point, would there have been enough braking distance to bring the aircraft weighing 180 tons at a landing speed of 260 km per hour to a stop before the end of the runway?	The air weighed 161.4 tons, not 180 tons. The answer to this question is unequivocally: YES.	Refer to landing distance analysis.
142. Could the point where the Anthony Ruys first touched the runway be due to a combination of poor visibility and the lack of an ILS Instrument Landing System) at that airport?	Answer BVO	No.
143. Shouldn't there be specific limits for the conditions when landing is still permitted at airports where there is no ILS (Instrument Landing System).	There are such [limits]. This relates to increased values for visibility and cloud base, which were easily fulfilled in this case.	Yes, the minimum decision altitude is higher and the required horizontal visibility, greater.

8.9. THE "REVIEW AND REMARKS AND QUESTIONS - CLAIMANTS OF INTERIM REPORT V17 FARO"

8.9.1. PREAMBLE

The Experts want here to thank again the Claimants advisors' team for the work done to issue the "Review and Remarks and Questions of Interim Report V17 Faro".

Following the analysis of this document, improvements have been made to the interim report to explain or clarify some points.

Nevertheless, the general feelings, when reading these remarks, are that the aim of the Claimants advisors' team is to underline a liability, either from the crew, or the airline, or against the Dutch authority and its representative, the DASB (RvDL at the time of the accident).

Again, the Experts want here to underline once more that the aim of the work of the Commission of Investigation, according to the recommendations of the Annex 13 of the ICAO, is not to define liability but to define causes and/or contributing factors to improve, downstream, the flight safety.

In this context, DASB, as part of the Commission of Investigation, was not allowed to define liability.

Particularly with respect for the victims and their families, the Experts decided to answer as far as possible to these "Review and Remarks and Questions of Interim Report V17 Faro", in accordance with § 0.1.2. of the preamble of this final report, and with respect to the limits raised by the Judge¹⁵².

Notes :

- The used of the term "No Comment" will mean "No more comment that the ones already raised in the core of this report or in its annexes"
- The used of the term "Not relevant" will mean "Out of scope"

8.9.2. EXPERTS' COMMENTS

Answers and comments, if applicable, to the "Review and Remarks and Questions of Claimants of Interim Report V17"

¹⁵² The court has decided that the experts - in their final report - only need to respond to the comments of either party where these comments concern the actual content of the draft-report.

Reference inside the claimants advisors' team's review	Text by the claimants advisors' team (if appropriate)	Comments by the Experts	Additional remarks
1	Introduction		
1.1	Scope		
1.1.1	 Following an independent analysis by AvioConsult, the lawyer subpoenaed the DASB, and therefore the State for: 1. Inappropriate, careless investigation of the cause of the accident, and 2. Misinforming the survivors and the next of kin of the deceased. 	This is inappropriate because the DASB was not in charge to investigate the cause of the accident but was only part of the Commission of Investigation according to the ICAO Annex 13. The Portuguese authority was in charge of the investigation and appointed a Portuguese official to lead the Commission of Investigation. DASB was part of this team. The answer to the point n°2 is detailed in 0.1.3.2 of this report	ICAO Annex 13
1.2	Review		
1.2.1		No comment	
1.3	Structure	No comment	
1.3.1		No comment	
1.3.2		It would have been preferable to have chosen a structure already used either in the official report (RvO) or in the interim report of the Experts (V17) to facilitate the analysis. Moreover, it would have been practical to source each remark by its precise reference in one or the other of the existing reports. This structure leads to an additional and useless workload for the Experts to set up a correspondence in between the available documents and this "Review and Remarks".	

1.3.3		Particularly with respect due to the victims and their families, the Experts will issue answers or comments in accordance with the indications provided by the Judge.	Note provided to the Experts by the Judge with the "Review and Remarks and questions – Claimants of Interim report V17"
2	Fight preparation		
2.1.	Landing gear	The aircraft was "Good for flight" according to the approved procedures (manufacturer and authorities {FAA and Dutch authorities}	RvO §1.6.3 alinea 2 : "The items pending at the date of the accident did not affect the aircraft airworthiness"
2.2	Thrust reverser	All the procedures were fully respected before the dispatch. The "reverser" item was a (*) consult item. See 8.6.4.1.2 « The Technical Status of the Aircraft »	The MEL is a document approved by the Authority issuing the Air Operating Certificate. It is based on the MMEL approved not only by the FAA but also by the certification authority, in our case, the Dutch authority. As soon as the MEL is respected, it is not necessary to organize any contact with the Authority. At the opposite, a contact will be mandatory to obtain a dispatch clearance out of the MEL (technical flight,)
2.3	Flight crew experience	No comment	
3	En-route and initial descent		
3.1	Weather changes en-route and initial descent	No comment	
3.2	Arrival briefing	No comment about the content of the briefing. Remember that all these considerations are of no consequence because the landing distance is definitely neither a cause nor a contributing factor to	Thanks to the Claimants' advisors team for the landing weight correction. Nevertheless, the Experts underline that the exact limitation was 192,3 tons and not 193,2 tons.

		the accident	
		the accident.	
4	Approach		
4.1	Approach Stability	The Claimants' advisors describe here the aerodynamic stability, which is a certification criterion. In this case, the term "Approach stability" refers to an operational meaning related to the flight path and not to the aircraft itself. For an airline pilot, the term "stabilized" or "stabilization" or "stable" is definitely not related to aerodynamics but to the followed flight path. The right term is not "Approach stability" but "Approach Stabilization". Also the Experts want to underline that there are many external and/or internal causes to destabilize an approach.	
4.2	Outbound radial, inbound turn and establishing on the approach		
4.2.1 to 4.2.2.12		No comment	
4.2.2.13	The captain confirmed to see the runway from 4 nm out.	As soon as the Captain said that he had the runway in sight, all the considerations presented previously by the Claimants' advisors are no more to be considered because the approach is not any more a non-precision approach but a visual approach, even if the crew continued to help themselves using the information provided by the electronic devices (DME, R NAV, VOR).	
4.2.2.14		The Experts have no knowledge of the meaning of the term "beaufort" in aviation.	
4.2.3	Comments DASB		
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4.2.3.1		No comment	
4.2.4 to		No comment	
4.2.4.2.2			
4.2.4.2.3		The Claimants' advisors do not provide the solution to use the autopilot to intercept the 111° radial: this interception was only possible using the heading mode of the autopilot (and flight director). On the KSSU standard, it was not possible to intercept automatically a VOR radial.	
4.2.4.2.4 to 4 2 4 6 1		No comment	
4.2.5	Other remarks and Questions		
4.2.5.1 to		No comment	
4.2.5.5	The stores 20 bits in the sight would be seen	No. a strange wind at 1500 fact and black and a set a	
4.2.5.0	The strong 30 kt wind from the right would be way too high for landing. This should have led to a go-around also at this point, 3.5 min before landing.	reason to go-around	
4.2.5.7 to 4.2.5.10.2		No comment	
4.2.5.11	Experts question the accuracy and the source of the maps used in the investigation (V17 § 8.6.4.5, page 105) and present three possibilities 8 nm are accurately shown. Hence, the plot of the inbound track is accurate as well. In the same NOTE, the Experts state: " <i>For the</i>	Answering to these two remarks, the interim report V17 has been clarified for a better understanding.	

	DC10 inertial systems, the accuracy is of 1 NM/hour, constantly maintained depending on the useful radio-aids systems. The best performance happens with a dual-DME updating system and is therefore maintained around 1 NM, meaning an imprecision radius of 2 km"! This is not true. The drift of an INS is 1 but the Commission used ground radar data though, not INS data. Experts are obviously not familiar with the operation of an INS and have no expertise of ground radar and other positioning systems for logging the track of an aircraft. They should not have mentioned this.		
4.2.5.13		No comment	Note : As soon as the Captain has the runway in
4.2.5.14			sight, these considerations are not relevant.
4.2.5.15		No comment	
4.3	Approach speed		
4.3.1 to 4.3.5		No comment	Note : according to the AOM 3.3.5 – 03 Wind Correction Factor, the note below the table indicates on its second paragraph, that the ATS will add automatically 5 knots to the selected speed in the ATS window in case of gusting conditions. The Claimants' advisors themselves confirm this automatic increment of 5 knots on airspeed when ATS are ON because of turbulence (Ref § 4.4.4.1 of their "Review and Remarks and Questions")
4.4	Alleged windshear during the glide path		
4.4.1 to 4.4.5.8.3		No comment No new evidence.	
4.5	Glide path		The use of the term "Glide" is inappropriate for a classical (non-precision)VOR-DME approach.

4.5.1 to		Some minor correction has been introduced in the	
4.5.5.3		interim report V17	
4.5.5.4		From the available graph on the provided	Note : The Experts did not use ground speed to
		documents, the actual height has been put in front	compute a vertical speed because the result would
		of time reference and the vertical speed is then	have been obviously an instantaneous vertical
		computed each 5 seconds.	speed, data definitely useless for a pilot because of
			its high rate of changing.
4.5.5.4.1 to		No comment	
4.5.5.7			
4.5.5.8		Some corrections have been implemented in the	
		core of the final report on the related graphs.	
4.6	Flooded runway, definition and awareness	The Experts want again to underline that the status	
		of the runway is definitely not a cause or a	
		contributing factor of the accident.	
		The experts confirm that at the time of this message	
		(07.28:56 of the official report around 10 [nm] from	
		touch down), the captain did not put the safety of	
		the aircraft at risk on continuing the approach	
		The Experts want to underline that the crew of the	
		MP461 also received the same information also	
		disregarded it and performed a good landing with a	
		acod decoloration 153	
		They also want to confirm that the workload was	
		high during the last turn towards the final rath	
		night during the last turn towards the final path.	
		ivianaging the aircraft, "in-and-out" an active	
		thunderstorm, while preparing a change of	
		configuration, the interception of the final axis, with	

¹⁵³ This point leads to some comments indicating that the B767 should be a better aircraft than the DC10 or that the MP465 crew was not so professionnal as the MP461 one. Both ideas are definitely not appropriate.

	a flashing fuel cue-light, and the associated change of thrust, is one of the parts of the flight where the workload is the heaviest. The use of the term " <i>Roger</i> ", nine (9) seconds after the transmission of the "flooded" information is the best evidence proving the level of workload. In these conditions, all the following comments about the understanding of this term by the crew issued the Claimants advisors' team are irrelevant or received detailed explanations in the previous paragraphs of this report. Nevertheless, the Experts will comment some points, as it could be important for the Judge to imagine the context and draw his own idea of the situation.	
4.6.1 to	No comment	
4.6.2.4	The Claimants advisors' team cannot provide any evidence that the crew of MP 495 heard the transmission to the MP461. The Claimants advisors' team can only say that this transmission is recorded on the CVR. The difference is not only semantic. It is well known that a message that is not at the intention of a crew is not necessarily listened or understood by this crew. To hear a message a crewmember must be ready to hear it. This is a constant of the Human Factors principles about the communication.	
	are issued by ATC and recorded on the CVR of an	

	aircraft, and the crew hears them unconsciously without paying them specific attention. The individual call sign triggers a caution flag for the crew : as soon as this specific call sign is issued, the attention is focused on the subsequent information. This is the reason why the Experts cannot take into consideration as evidence that the message issued for the MP461 flight was definitely heard by the MP465 crew.	
4.6.2.5	No more comment than already detailed for paragraph 4.6	
4.6.2.6	The Experts cannot accept the position of the claimants advisors' team when they suppose, and guess who from their point of view, that a CVR transcription has been modified	
4.6.2.7 to 4.6.2.8	In the first statement, the captain says that he knows the meaning of the term flooded, as an answer to a police question. But he said also "in my mind this condition did not exist during our approach". In the second one several months later, he says that he has interpreted in flight the term "runway is flooded" as wet runway conditions. And in addition he makes a remark about the non- standard term flooded.	

	There is no contradiction here, only a same event commented at different times. The two statements do not prove that in "the second statement the captain claims to have no knowledge of the meaning of the term "flooded" . The Experts consider the two statements as complementary one each other.	
4.6.3.1	The experts estimate that if the pilots have lost the control of the aircraft under 500 [ft] after a normal final approach, the comment of the DASB about extreme conditions is comprehensible.	
4.6.3.1.1	No comment	
4.6.3.2 & 4.6.3.2.1	No comment	
4.6.3.2.2	Refer to 4.6.2.7 It is not a task of the Experts and they are not in position to comment on this kind of potential procedures issues.	
4.6.3.2.3	Refer to 4.6.3.2.2	
4.6.3.2.4	Assuming that the pilot has interpreted the term "flooded" as "standing water", and subsequently that the runway would have been too short, at eight (8) or even four (4) minutes before touch down, the captain is entitled to postpone the go-around decision because at this moment there is no immediate threat for the aircraft.	

4.6.3.2.5	Refer to 4.6.2.7 For the one hand, DASB as part of the Commission of Investigation was not in charge to define liability. For the other hand, DASB had no reason not to believe the Captain in his statement.	
4.6.3.3 & 4.6.3.3.1	No comment	
4.6.3.3.2	It is true that there is no reference to the captain statement on December 1992 regarding his knowledge of the term "flooded". The Experts of course cannot provide any certainty about that. A lot of explanations are possible (non exhaustive list): - Either the DASB representatives during the claimants' meeting had an insufficient knowledge of the file. - Or they found it unnecessary to recall this point, considering that this was not a cause of the accident. - Or they considered that despite the knowledge of the captain about the term "flooded", he took it as that the runway was wet.	
4.6.3.3.3	Not relevant according to the previous comment.	
4.6.3.4	Not relevant according to the previous comment.	
4.6.3.4.1	No comment	

46342	No comment
1.0.0.1.2	
4.6.3.5	A 100% certainty is never a reachable target.
4.6.3.5.1 to 4.6.3.10.1	No comment
4.6.3.10.2	On the ATC tower, the SIO wind page was set on runway 29 instead of runway 11 meaning the ATC controller was not aware of this wind.
4.6.3.11	DASB is right when he asked to delete this sentence. Because it is true as the captain's statement proves it (see 4.6.2.7).
4.6.3.11.1	The comment of the claimants advisors' team is not appropriate.
4.6.3.12	No comment
4.6.3.13 to 4.6.4.2	Not relevant
4.6.4.2.1	Already answered. Refer the comments to 4.2.4.4 : Refer to the document registered as Lijst-4 map-1-sur-4, page 27/624 pdf – F/E's statement : "It caused the aircraft pitch to increase to maintain altitude. This attitude change caused the auto throttles to increase thrust to approximately 100% N1 for approximately 4 to 5 seconds to maintain selected speed. When the aircraft pitch increased, the fuel pressure warning light briefly illuminated and both Captain and First

	Officer reacted to the "fuel cue light-on" on the	
	forward panels to query the light."	
4.6.4.3 &	No comment	
4644		
1.6.1.1	By experience and their high knowledge of Human	
4.0.4.4.1	Dy experience and mention	
	Factor in theory and practice.	
4.6.4.5	No comment	
4.6.4.5.1	Refer to the previous answer at 4.6.4.4.1	
1616to	No comment	
4.0.4.0 10	No comment	
4.0.4.7.1		
4.6.4.7.2	The Experts do not change anything.	
4.6.4.8	No comment	The Experts made a mistake : the JAR OPS-1 was
		issued of 22 nd May 1995.
		But the JAR OPS is the result of a long transition
		period during which the national rules converged
		period during which the final target, and along 5.2.2.2 and
		slowly towards the final target; see also 5.2.2.3 and
		8.6.4.4.2).
		Nevertheless, it is true that the term "flooded" was
		not used in the KLM/ Martinair documentation.
46482to	No comment	
1.6.1.11		
4.0.4.11	Mact important in this case is that the indicated	
4. <mark>0</mark> .4.11.1		
	wind on the instrument available to the ATC	
	controller was the actual wind for runway 29.	
4.6.4.11.2 &	No comment	
46412		
1.0.1.12	Put the crow did not understand that the runway	
4.0.4.12.1	but the crew did not understand that the fullway	
	was flooded and used the wet conditions. This is	

	confirmed by the CVR (briefing approach)	
	commed by the over (bilening approach)	
464122	No comment	
1.0.1.12.2		
4.6.4.12.3	No comment	
4.6.5		
4.6.5.1	Already answered	
-		
4.6.5.2	This question is inappropriate.	
	The captain understood "wet runway"	
44501	Defer to answer to 4.6.2.7	
4.0.3.2.1		
46522	The captain understood "wet runway"	
4.0.3.2.2	The captain understood wetranway	
4.6.5.2.3	The Captain understood "wet runway", and for him	
	there was no reason to request a confirmation.	
4.6.5.2.4	Nearby a stormy area, the weather can change very	
	quickly, this informal remark has no real operational	
	impact.	
	No commont	
4.0.5.2.5 10	No comment	
4.0.3.3	None. It is the normal job of a pilot to try to land at	
4.0.0.3.1	the destination airport	
4.6.5.4 to	No comment	
4.6.5.5.1		
4.6.5.5.2	Already answered	
4.6.5.6 to	No comment	

4.6.5.8.3			
4.7	Conclusion of the Experts on the Approach	No comment	
4.7.1 to 4.7.3.3		No comment	
4.7.3.4		The pilots reported to have the runway in sight from 4 [Nm] (or 1200 [ft]) and confirmed to ATC at 1100 [ft]), The visual contact with the runway was effective at 1200 [ft].	
4.7.3.4.1		DASB says " <u>according to the crew statement</u> the aircraft was correctly in the slot for landing, down to an altitude of 200 [ft]". It is the exact sentence written in the final Portuguese report (English version) but the exact statement of the captain is "at 200 [ft] we were on the center line in the slot for landing"	
4.7.3.5 to 4.7.3.8			
4.7.3.9		Not true. Although very late, the aircraft reached the runway centerline.	
4.7.3.9.1		No comment	
4.7.3.9.2		The Experts cannot agree with the term "intentional" used by the Claimants advisors' team.	
4.7.3.10		See § 8.6.4.5 revised (of the final report of the Experts) with a picture of the document CR93080C mentioned in the official final report.	
4.7.3.10.1 and		See 4.7.3.10	

4.7.3.10.2			
4.7.3.11		No comment	
4.7.3.12		Not applicable. The Experts have a transcription of the CVR. However, the exchanges did not show overconfidence but simply a professional crew performing their work professionally.	
4.7.3.12.1		The Experts confirm their initial evaluation	
4.7.3.12.2		No comment	
5	Final Approach and touchdown		
5.1	Minimum decision altitude		
5.1.1 to 5.1.2.4		No comment	
5.1.3		Refer to 4.7.3.4.1	
5.1.4 to 5.1.5.1		No comment	
5.1.5.2		The Captain did not verbally underline the "500 feet" gate neither at 400 ft. But neither the PF nor the Captain called out for a go-around.	
5.1.5.3		When there is some rain, you obviously use wipers to enhance the vision outside. This is not what a pilot call a loss of visibility.	
5.1.5.4		Yes, it is true. But the F/E understood perfectly what the F/O was really asking for.	

	This exactly what is called "communication" by the Human Factors principles.	
5.1.5.5	No comment	
5.1.5.6	The Experts want to remind that the destabilization begun more or less at this altitude. The probable reason of the mistake is the predominant stress.	
5.1.5.7 to 5.2.4.2	No comment	
5.2.4.2.1	That is true. But the communication is not only verbal and a gesture sometime is often enough to inform everybody about a decision. The increase of thrust could be exactly the evidence of such a gesture.	
5.2.5		
5.2.5.1	Normal job. The crew calculates usually the landing data card when it performs the before descent and approach briefing, then using the last weather forecast issued either by an ATIS or on request. Then it is an airmanship behavior to modify the data if necessary.	
5.2.5.2	The Claimants advisors' team cannot say on the same sentence that the wind varied in strength and	The Experts want again to underline that a thunderstorm was quite close the final approach

5.2.5.2.1		direction and ask the crew to use a wind provided by the tower using a wrong reference more than 5 minutes prior the scheduled landing. Already answered or commented	path. Consequently the wind variations are a normal situation in this case.
53	Rate of Descent		
5.3.1 to 5.3.2.1		No comment	
5.3.2.2		The Claimants advisors' team uses inappropriately the term "radar altitude".	
5.3.2.3		The Experts want to clarify a point. The radio-altimeter indication is not so accurate : the measurement is performed perpendicularly to the plane and not vertically. That means a rapid variation of the bank angle induces an error of indication well known by the pilot performing a visual pattern at a low altitude. During the last turn, rapid changes of bank angles can occur, enough to trigger false GPWS warning. The radio-altimeter indication is then really accurate when the approach is smooth or rather smooth with small bank angle correction. Obviously, this indication is also dependent of the ground profile.	
5.3.2.4 to 5.3.3.1.1		No comment	
5.3.3.2		No. The conclusion of the Claimants advisors' team is not acceptable. The absence of GPWS warning does not show that "the rate of descent was not high" : it shows only	

	that the limits which trigger a warning (here GPWS) were not exceeded.	
5.3.3.3	The term "tried to persuade" is not appropriate.	The Claimants advisors' team uses many time this term to reach their aim, that is to persuade the reader that DASB did a wrong job. In this case, as for many cases, the position of DASB is not wrong. And remember that as a member of the Commission of Investigation, the DASB' job is exactly to make proposition to this Commission, then to discuss the final wording. It is a constant among the Claimants advisors' team to consider the DASB as separate from the Commission of Investigation: This is a major mistake; the DASB is a part of the Commission of Investigation and must act in accordance with this role clearly defined by ICAO Annex 13.
5.3.3.3.1	The Experts also note that the Claimants Advisors' team considers that the decreasing of the vertical acceleration could be an evidence of a possible go- around, in contradiction with what they are expressing in some previous paragraphs.	
5.3.3.4	This paragraph is important. During this investigation, the NLR was appointed by the Commission and not by the DASB. Consequently, the DASB was not in a position to	

		1
	allow the NLR to issue any part of an official	
	document without the authorization of the owner of	
	this document, i.e. the Commission of investigation	
	this document, i.e. the commission of investigation.	
5.3.3.5 to	No comment	
5.3.4.1		
53411	Refer to the core of this report and 4.5.5.4 of	
	chapter 9.0.2 "Exports Commonts"	
	chapter 6.9.2 Experts confinents.	
5.3.4.2	No comment	
5.3.4.2.1	Refer to the core of this report	
535to	No comment	
5251		
0.0.0.1		
5.3.5.1.1	If the remark is relevant, the best is to ask the NLR	
	itself. The Experts cannot answer for this laboratory.	
5352&	No DASB is not responsible for the NLR report	
53521	neither the Commission of Investigation NI D is	
3.3.3.2.1	neuron the commission of investigation. IVER IS	
	responsible for its report. DASB is neither	
	responsible for the decision of the Commission of	
	Investigation to appoint the NLR for this study.	
	DASB proposed this laboratory and the Commission	
	and the Commission and the Commission	
	appointed it.	
5.3.5.3 to	No comment	
5.3.5.6		
5.3.5.7	The F/O's action plan was to land ! In this case	

		proventing on increases of thrust is a normal	
		preventing an increase of thrust is a normal	
		behavior because of the risk of increase of landing	
		distance !	
5.4	Premature thrust reduction		
5.4.1 to		No comment	
5.4.1.4			
5421		Already commented	
0.1.2.1		A would be a marked	
5 / 2 2 to		No commont	
5.4.2.2 10		No comment	
5.4.5.2			
5.4.5.3		The ATS has full authority to reduce the thrust to	
		flight idle if necessary and this flight idle is around	
		45 %	
5.4.5.4		No comment	
5.4.5.4.1 to		The Experts never talk about a wrong functioning of	
5455		autoflight systems	
5156		Net relevant	Assortions not sustained by evidences
0.4.0.0		NULTEIEVAIL	Assertions not sustained by evidences.
5.4.5.7 to		No comment	
5.4.5.8.2			
5.5	Control inputs during final approach		
551 to		No comment	
55521			
5.5.5.2.4			
5.6	Autopilot disengagement		
5.6.1 to 5.6.5		No comment	
57	Go-around attempt		
5.7 E 7 1 to E 7 4		Ne commont	
5.7.1 10 5.7.4		NO COMMENT	

5.7.4.1.1		Please explain	
5.7.4.1.2 to 5.7.5.2.1		No comment	
5.8	Alleged Lateral Displacement Just Prior To Touchdown		
5.8.1 to 5.8.5.7.1		No comment	It is not possible to deny the lateral displacement during the approach: at 200 ft., the aircraft is on the extended center line of the runway, and the touchdown occurred on the left-hand side on the runway 11. The reasons for this displacement was investigated by the Commission of Investigation which includes the DASB. After discussions and expertises, the Commission concluded that the causes were a huge modification of the aerological conditions. The mission of the Experts is not to evaluate the conclusions of the Commission
5.9.1 to 5.9.5.4.1		No comment	
5.9.5.4.2		This comment is not acceptable. A good expert knows that the analysis of a situation does not at all time conduct to a binary result. Technical considerations are not in themselves sufficient and must be merged with variable inputs such as Human Factors or environmental conditions. Wisdom is a fundamental law in this matter. If everything was easy to understand or to clarify, it would not be necessary to use experts'	

		competencies.	
		In this context, the use of the words "should",	
		"could", "would" is highly justified.	
5.9.5.5		No comment	
5.9.5.5.1		No comment	
5.9.5.6 to		Not relevant	
5.9.5.7.1	Deint of Touchdown on the runwou		
5.10	Point of Touchdown on the runway		
		The translation of the question could be	The touchdown zone of a runway is the best
		inappropriate: It should rather be titeled "location	compromise in between the length of the runway
		where the aircraft crashed " instead of "point where	and the clearance from obstacles in short final.
		the touchdown occurred".	The best demonstration the Experts can provide for
			all these questions of touchdown is the following
			1) At takooff the weight of an aircraft is abviously
			higher then for the lending
			2) The performance at takeoff is calculated to
			accelerate at least to a specific speed and in
			case of failure, to decelerate, without exceeding
			the limit of the runway. When exceeding this
			specific speed, you must take off, meaning
			stopping the aircraft in the remaining runway
			length is not anymore possible
			This consideration means that taking off from a
			rupway which longth is 2400 m for example will
			runway which length is 2400 million example will
			result in accelerating during 1400 m more or
			less, then, it necessary for example in case of
			engine failure, in decelerating, at the maximum
			operational take off weight, using less than
			1000 m, i.e. the remaining runway length.

			All these considerations to say that touching down at 1000 m from the threshold will not necessarily result in an accident. This is obviously not recommended and the standard is to land between 300 m (not before because of the obstacles) and 600 m (to avoid a huge use of the brakes). 900 m is already too much. And obviously, you should correct the deceleration capabilities according to technical and operational data (i.e. a brake inoperative or a reverser stowed or a runway wet or contaminated, or tail wind) Speaking, as the Claimants advisors' team said, of "268 m" as the touchdown point is a non-sense.
5.11	Landing gear failure		
5.11.1 to 5.11.6.21.1		No comment	
6	Cause of the accident by the Experts		
6.1	Conclusions and Recommendations Draft Report changed by DASB		
6.1.1		No comment	
6.1.2	"6.1.2.1 DASB tried to persuade the Commission during a visit and with deletions and additions in the Report RVDL3 (lijst 4 tab 23) to change the causes to:"	All along this paragraph, the Claimants advisors' team uses the term "DASB tried to". DASB did its job as member of the Commission of Investigation. This is, perhaps, the most important point : As member of the Commission of Investigation, DASB becomes independent of the Netherlands authorities. Simultaneously, as expert appointed to the Commission of Investigation in agreement with the	

		ICAO Annex 13, DASB is not independent; it is a part of the Commission of Investigation and must provide the Commission with all its opinions and analysis.	
6.1.3		The Experts used another wording to underline the fact that the accident is due to the contact with the ground. Doing so, the Experts underlined the fact that a decision to go-around will be enough to save the plane and its passengers, exactly what the Claimants advisors' team is trying to say from the beginning of their contributions. But the problem is not here: the accident occurred and we are not in charge to define any liability ; we have to define if whether or not, DASB performed its job in due care.	
6.1.4 to 6.1.4.5.7		No comment	
6.2	Conclusion Experts	No comment	
6.3	More Conclusions Experts	No comment	
7	Other Aspects	No comment	The Experts explained why they considered important to performed their own analysis, validating such point or at the opposite, raising such or such question, for example about the Human Factors

	considerations. Otherwise, it would be quite difficult
	to answer the questions raised by the Judge about
	the quality of the work performed by the DASB
	during this investigation.