

An exchange over the Singapore Airlines crash in Taiwan

27 November 2000

Hello,

I would like to take issue with some of the claims in this story. I was an Air Traffic Controller in the U.S.A.F. for four years from 1979-1983.

“The intended runway was near the one under repair and the two had almost identical identification numbers, adding to the chance of confusion.”

While generally true, is absurd. Parallel runways are common throughout the world and are labeled by magnetic heading and L, R, C, for left, right, center. All runways are marked with large numbers painted on them and also with little streetsign like markers near the edge. If you have ever flown you can see them easily while the plane taxis. If he was unfamiliar with the airport layout he could have requested and received detailed taxi instructions from the Tower. Not to mention, he should have had a map out showing the plan view of the airport. It was simply carelessness on the pilot's part (assuming that the controllers didn't make a faux pas and tell him he was Cleared for Takeoff on the closed runway.) My bet, not knowing the airport layout, was that while going from the passenger terminal to the two runways, the crew were inattentive and just assumed that the first runway they came to, 05R, was the one to take. Had the construction been on 05L, this accident most likely would not have occurred.

“According to San Francisco-based attorney Gerald Sterns, who specialises in representing air crash victims' families, under such conditions the control tower should have warned the pilots by radio about the closed runway. ‘The “black box” cockpit recorder indicated that wasn't done with the Singapore Airlines flight,’ he said.”

This is a false claim. When the pilot files his flight plan he would be told all about all Hazards to Air Traffic for the airport. These include closed runways, navigation aids broken, lights not working, etc. It would not be necessary for this information to be told again while the plane was cleared to taxi to a particular runway. So if this information was not on any Black Box tapes it would not mean it wasn't known by the pilots.

“‘The use of ground monitoring would certainly have ensured the crash in Taiwan would not have occurred,’ he added.”

This is also false. It is akin to saying that since en route traffic is monitored by radar, no collisions can occur.

Why is it so hard to accept the fact that people make mistakes. Although I don't think the pilots should be charged with a crime, it is a fact that from what is known, they are the cause of this. No amount of spending or safety oversight will prevent humans from having accidents.

Regards,

RW

Dear RW,

I have carefully read through your comments on the WSWWS article

“Authorities scapegoat pilots for Singapore Airlines crash in Taiwan” dealing with the fatal crash of Singapore Airlines flight SQ006 at Taipei's Chiang Kai-Shek International Airport on October 31 that claimed 82 lives.

Unlike you, I have not worked for years in the airline industry and don't claim to be an expert in air safety. But what informed the article is the understanding, borne out of long experience, that whenever an accident occurs in industry or transport, there is almost always a rush by the authorities and the media to find a convenient scapegoat in order to sweep troublesome questions about the deeper causes under the carpet.

Certainly all the evidence points to such a conclusion in relation to the SQ006 crash in Taiwan. The Taipei Airport Authorities rushed to blame the pilots for the accident even though the official investigation had hardly begun and the media immediately seized on “pilot error” as the cause. The article simply pointed that out and then raised a number of issues that had already been highlighted by pilots associations, recognised experts and the investigators on the ground in Taipei.

We were not the only ones who were concerned at the rush to judgment. On November 15 the president of the Malaysian Airline Pilots Association (MAPA), Captain Datuk Mohamed Johan called on the Taiwanese authorities to refrain from immediately blaming the pilots. He warned that “it is very unwise to make an immediate judgment on the incident without ascertaining all the facts”. His sentiments were endorsed by an on-line petition signed by over 1,000 pilots.

What is disturbing about your email, especially as you have experience in aviation, is that you simply dismiss anything that points to inadequacies in the operating procedures of the airport or airline. As far as you are concerned, the pilot made a mistake and that is it—nothing could have been done about it and there is nothing to be learned. In other words, the cause of the crash was gross negligence on the part of the pilot without any mitigating circumstances whatsoever. To my knowledge, no one else has reached such a categorical conclusion and, on your own admission, you have no particular information about either the airport or the crash.

Of course, in the strictest sense, “pilot error” was involved: the pilots lined up on the wrong runway, which was under repair, struck a concrete barrier and heavy construction equipment causing the aircraft to split in three and crash. But, as several air safety experts have pointed out to us that is not the end of the story, only the beginning. No-one has suggested that the wrong runway was chosen deliberately, so the question remains: what would lead an experienced pilot to make such a mistake and, just as important, what can be done to ensure that such a tragedy does not happen again?

Let me deal with each of the points in your email:

1. You dismiss as “absurd” the possibility that the similarity in the lettering on signs marking the parallel runways could have led to confusion. Runways are “labeled with magnetic headings and L, R, C indicating left, right and centre” and “have large numbers painted on them,” as well as “little street sign like markers at the edge”.

An article by Associated Press writer William Forman on November 4 indicated that the markings at Taipei airport are somewhat more confusing. He pointed out that the runway the pilot was supposed to use was marked “5L-23R” and the closed runway marked “5R-23L.”

Forman explained that investigators have already speculated that the signs could have caused confusion. “With visibility low because of the blustery winds and driving rain, the pilot saw a “5” on the sign and an “L,” while not noticing the other letters and numbers on the sign. Thinking he was on the correct runway, he took off,” he wrote.

As I explained in the article, there are also outstanding questions concerning the lighting of both runways, which could also have caused the pilot to draw the wrong conclusions. You do not comment on the fact that the runway under repair should have been blocked and unlit to comply with international airport regulations.

2. You then add “if the pilot were unfamiliar with the airport layout he could have requested a map”. That is certainly the case, but as our article pointed out, Captain C.K. Foong had used the airport on a number of previous occasions, suggesting other factors were at play.

A more recent article in the *Taipei Times* on November 8 casts some doubt on the accuracy of information provided by the airport. It reported claims by Cathay Pacific that a map issued by the airport authority to airlines prior to the accident contained incorrect information.

“The Cathay Pacific spokesman said that according to the map, runway 05R was to be closed for repair effective at 1am on November 2 local time, when in fact it had been out of service for takeoffs and landings since September 13. The crash occurred on October 31.” The article is accompanied by a photograph of Independent Legislator Lin Ruey-tu at a press conference displaying two different versions of the charts issued by the airport authorities.

3. You also reject the suggestion by San Francisco-based attorney Gerald Sterns, who specialises in representing air crash victims' families, that given the prevailing weather conditions the control tower should have “used its radio to warn pilots about the closed runway to make sure they aren't using it.” Sterns stated that the “black box” cockpit recorder indicated that this was not done.

You are aware, although you do not refer to it in your email, that the plane was attempting to take off in typhoon conditions with cross winds up to 88 kph and lashing rain. The airport authorities admitted visibility was down to between 500 and 600 metres. Why not take the extra precautions?

Yet you say that the action suggested by Sterns is a “false claim” because when a pilot files his flight plan “he would be told all about all hazards to air traffic for the airport” including “closed runways, navigational aids broken lights not working etc.” In such weather conditions why not double check?

Your suggestion only raises further questions. Were the pilots briefed correctly? Was the information they were given accurate? And, given the prevailing weather conditions, was this procedure adequate to prevent them from making a fatal mistake? You simply assume, without providing any evidence one way or the other, that everything went to procedure and that the procedures were adequate.

4. Finally, you reject as “false” the opinion of Dr Graham Braithwaite, an aircraft safety expert at the University of New South

Wales in Australia, that ground monitoring radar would have ensured the crash would not have occurred. You contend that Braithwaite's claim is akin to saying that “since en route [air] traffic is monitored by radar, no collisions occur.”

But the situations are hardly analogous. Under the conditions that prevailed at Taipei airport, no visual check of the aircraft's position was possible. If there had been an air traffic controller who could have done a final check on the aircraft and the runway it was on prior to its takeoff, then surely the likelihood of such a tragedy could have been significantly reduced, if not avoided altogether. If that is not the case, then why would other airports bother to install ground monitoring radar at all?

Undoubtedly a great deal remains to be examined. Yet you claim—prior to the completion of the investigation—that the accident was unavoidable and therefore that nothing can be done to prevent similar disasters in the future. You write towards the end of your email: “Why is it so hard to accept the fact that people make mistakes? No amount of spending or safety oversight will prevent humans from having accidents.” Here is the crux of your argument.

Of course people make mistakes—that is the reason why safety procedures, equipment and training are necessary in the first place. But you are suggesting that these are all costly overheads that can be dispensed with since accidents happen regardless. Such comments reflect the thinking of those in the airline industry who have presided over the steady erosion of air safety standards that has taken place during the last couple of decades as a result of deregulation and constant cost cutting.

Under the pressure of tight margins, hostile takeovers and cutthroat rivalry, air safety has been increasingly sacrificed to the requirements of profit and the markets. Pilots are being pushed to work longer hours increasing the dangers of fatigue; ageing aircraft are kept in service; maintenance is being contracted out and downgraded; airports fail to install the latest technology; and the list goes on.

The real truth is that safety, whether in air transport or any other industry, in the final analysis boils down to a question of time and money. That is why the runway under repair at Taipei airport was used for taxi-ing and not completely blocked off, why ground radar was not installed at the airport, and why pilots are under pressure to take off in bad weather, even if it may not be entirely safe to do so.

These are just some of the factors identified by experts that may have contributed to the crash that claimed the lives of 82 people. The danger is that, in the interests of commercial viability, they will continue to be overlooked, leading to the risk of further tragedies.

Yours sincerely,

Terry Cook

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