

COMANDO DA AERONÁUTICA
CENTRO DE INVESTIGAÇÃO E PREVENÇÃO DE
ACIDENTES AERONÁUTICOS



FINAL REPORT
I - 055/CENIPA/2021

OCCURRENCE:	INCIDENT
AIRCRAFT:	PR-OMW
MODEL:	EC 225 LP
DATE:	15APR2021



NOTICE

According to Law n  7565, dated 19 December 1986, the Aeronautical Accident Investigation and Prevention System – SIPAER – is responsible for the planning, guidance, coordination, and execution of the activities of investigation and prevention of aeronautical accidents.

The elaboration of this Final Report was conducted by taking into account the contributing factors and hypotheses raised. Therefore, the report is a technical document reflecting the result obtained by SIPAER regarding the circumstances that contributed or may have contributed to triggering this occurrence.

The document does not focus on quantifying the degree of contribution of the different factors, including the individual, psychosocial or organizational variables that conditioned the human performance and interacted to create a scenario favorable to the accident.

The exclusive objective of this work is to recommend the study and the adoption of provisions of preventative nature, and the decision as to whether they should be applied belongs to the President, Director, Chief, or the one corresponding to the highest level in the hierarchy of the organization to which they are being forwarded.

This Final Report has been made available to the ANAC and the DECEA so that the technical-scientific analyses of this investigation can be used as a source of data and information, aiming at identifying hazards and assessing risks, as set forth in the Brazilian Program for Civil Aviation Operational Safety (PSO-BR).

This Report does not resort to any proof production procedure for the determination of civil or criminal liability, and is in accordance with Appendix 2, Annex 13 to the 1944 Chicago Convention, which was incorporated into the Brazilian legal system by Decree n  21713, dated 27 August 1946.

Thus, it is worth highlighting the importance of protecting the persons who provide information regarding an aeronautical accident. The utilization of this report for punitive purposes maculates the principle of “non-self-incrimination” derived from the “right to remain silent” sheltered by the Federal Constitution.

Consequently, using this report for any purpose other than preventing future accidents may induce erroneous interpretations and conclusions.

N.B.: This English version of the report has been written and published by the CENIPA with the intention of making it easier to be read by English speaking people. Taking into account the nuances of a foreign language, no matter how accurate this translation may be, readers are advised that the original Portuguese version is the work of reference.

SYNOPSIS

This is the Final Report of the 15APR2021 incident with the EC 225 LP aircraft model, registration PR-OMW. The incident was classified as “[EXTL] With External Loads”.

During the framing of the final approach for the Fortaleza Base, in a region of dense vegetation, approximately 1 km from the landing, there was an uncontrolled jettisoning of the external load.

After trying to locate, without success, the exact location of the load fall, the aircraft proceeded to the destination and performed a normal landing.

The aircraft had no damage.

The pilots left unharmed.

An Accredited Representative of the *Bureau d'Enquêtes et d'Analyses pour la Sécurité de l'Aviation Civile (BEA)* - France, (State where the aircraft and the cargo sling were manufactured) was designated for participation in the investigation.



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GLOSSARY OF TECHNICAL TERMS AND ABBREVIATIONS

AFA	Air Force Academy
ANAC	Brazil's National Civil Aviation Agency
ASB	Alert Service Bulletin
BARO ALT	Barometric Altitude
BEA	<i>Bureau d'Enquêtes et d'Analyses pour la Sécurité de l'Aviation Civile</i>
CA	Airworthiness Certificate
CENIPA	Aeronautical Accident Investigation and Prevention Center
CMA	Aeronautical Medical Certificate
CMM	Component Maintenance Manual
COMAER	Aeronautics Command
CVA	Airworthiness Verification Certificate
CVFDR	Cockpit Voice and Flight Data Recorder
EC25	EC225 Aircraft Rating
EO	Operating Specification
IAS	Indicated Airspeed
IFRH	Instrument Flight Rating - Helicopter
LABDATA	Flight Data Recorders Read-Out and Analysis Laboratory
M'ARMS	Modular Aircraft Recording Monitoring System
MMA	Aircraft Maintenance Manual
OS	Service Order
PIC	Pilot in Command
PLH	Airline Pilot License – Helicopter
PN	Part Number
PPH	Private Pilot License – Helicopter
RBAC	Brazilian Civil Aviation Regulation
SAE-AE	Public Specialized Air Service Aircraft Registration Category - External Load
SB	Service Bulletin
SERIPA VII	Seventh Regional Aeronautical Accident Investigation and Prevention Service
SIC	Second in Command
SIPAER	Aeronautical Accident Investigation and Prevention System
SOP	Standard Operating Procedures
TPX	Non-Regular Public Air Transport Aircraft Registration Category
UTC	Universal Time Coordinated
VFR	Visual Flight Rules
VMC	Visual Meteorological Conditions
WDM	Wiring Diagram Manual

1. FACTUAL INFORMATION.

Aircraft	Model: EC 225 LP	Operator: OMNI Air Taxi S.A
	Registration: PR-OMW	
	Manufacturer: Eurocopter France	
Occurrence	Date/time: 15APR2021 - 1505 UTC	Type(s): "[EXTL] With External Loads"
	Location: Fortaleza Base	
	Lat. 05°00'07"S Long. 065°58'37"W	Subtype(s): NIL
	Municipality – State: Carauari – AM	

1.1 History of the flight.

The aircraft took off from the location known as "RNB-02", Carauari - AM, at around 1458 (UTC), to the Fortaleza Base, Carauari - AM, to carry out a specialized external load operation, with two pilots on board.

During the framing of the final approach for the Fortaleza Base, in a region of dense vegetation, approximately 1 km from the landing, there was an uncommanded jettisoning of the external load.

After the load was released the crewmembers tried to identify the place of the fall and write down the coordinates, which was not possible due to the dense vegetation (forest).

The aircraft proceeded to its destination, where it made a normal landing without damage.

The pilots left unharmed.

1.2 Injuries to persons.

Injuries	Crew	Passengers	Others
Fatal	-	-	-
Serious	-	-	-
Minor	-	-	-
None	2	-	-

1.3 Damage to the aircraft.

None.

1.4 Other damage.

None.

1.5 Personnel information.

1.5.1 Crew's flight experience.

	Flight Hours	
	PIC	SIC
Total	17.061:00	5.635:45
Total in the last 30 days	07:20	17:25
Total in the last 24 hours	00:00	00:00
In this type of aircraft	1.680:00	364:25
In this type in the last 30 days	07:20	17:25
In this type in the last 24 hours	00:00	00:00

N.B.: The data relating to the flown were obtained through interviews with the pilots.

1.5.2 Personnel training.

The PIC took the PPH course at EAPAC, Rio de Janeiro - RJ in 1988.

The SIC took the Aviation Officers Training Course at the Brazilian Air Force Academy (AFA), Pirassununga - SP in 1987.

1.5.3 Category of licenses and validity of certificates.

Both pilots had the PLH License and had valid EC25 and IFRH Ratings.

1.5.4 Qualification and flight experience.

The pilots were qualified and had experience in the kind of flight.

1.5.5 Validity of medical certificate.

The pilots had valid CMAs.

1.6 Aircraft information.

The aircraft, model EC 225 LP, Serial Number (SN) 2835, was manufactured by Eurocopter France in 2012 and was registered in the TPX and SAE-AE Categories.

The aircraft CA was valid.

The last aircraft inspection, the "Check 100 Hs 0500-100B" type, was carried out on 26MAR2021 by OMNI Air Taxi, in Jacarepaguá - RJ, with 19 hours and 50 minutes flown after the inspection.

The last inspection of the CVA type was carried out on 16DEC2020 by OMNI Air Taxi, in Jacarepaguá - RJ, with 24 hours and 10 minutes flown after the inspection.

The Maintenance records were registered in the "WINAIR" program, which received all information regarding the services performed on the aircraft, and it was verified that all records were updated.

The Field Action revealed that the ring used to connect the cargo to the aircraft hook was not within the measures recommended by the ASB EC225, nº 04A004, Limitations - SIREN Load Release Units: Load jammed on the cargo hook in the open position, Revision 0, dated 12MAY2009, by Eurocopter An EADS Company.

Likewise, it was also verified that the provisions of item 5 - Cargo Ring Size Rule, Section 9.1 Guidance for Cargo Sling Operations, of the Complementary Flight Manual, which also addressed the dimensions of the ring that should be used for the type of hook installed on the aircraft.

In this regard, page 14 of ASB No. 04A004, 12MAY2009, recorded a series of safety guidelines regarding loading the Cargo Hook.

Furthermore, the document warned that the use of rings not properly adapted to the size of the hook could, in some cases, lead to loss of external load.

Specifically, regarding the dimensions of the rings that should be used to hook the external load, the aforementioned ASB established the following parameters in case the helicopter was equipped with the SIREN cargo hook (Figure 1):

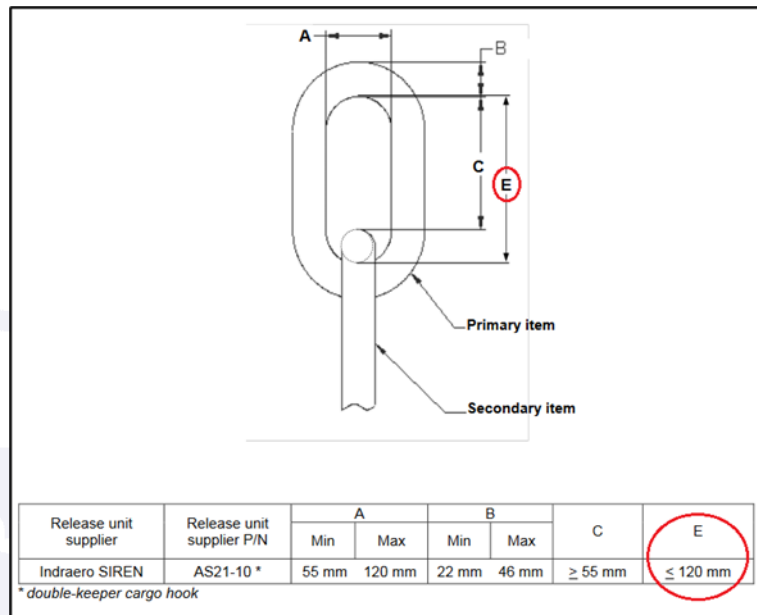


Figure 1 - Dimensions of the rings to be used in the cargo hooks of the manufacturer SIREN. Source: ASB No. 04A004, of 12MAY2009.

In this sense, as highlighted in Figure 2, it was found that the primary ring used to hook the load in the event measured 160 mm, that is, it was out of the 120 mm specifications, established in ASB No. 04A004, of 12MAY2009.



Figure 2 - Rings identical to those used to hook the external load at the time of the occurrence. The yellow lines indicate the inside measurement of the ring.

Likewise, the lack of the plate that should have been installed on the aircraft next to the cargo hook was observed (Figure 3).



Figure 3 - Plate containing loading guidelines for the cargo hook. Source: ASB nº 04A004, from 12MAY2009.

According to item 5 - Cargo Ring Size Rule of Section 9.1 - Guidance For Cargo Sling Operations of the Complementary Flight Manual, this plate contained, in addition to the dimensions provided for the primary ring, the following instructions:

- cables, straps and ropes must not be used directly on the cargo hook; and
- only one primary ring connected to a single secondary ring must be attached to the cargo hook.

It was also verified that, on the day of the occurrence, the mechanical actuation lever did not present a clearance adjustment as required for its installation, as prevised in the MMA 25-31-03-061, sub- task 25-31-03-431-001, 3.3 Installation of the release unit PRE MOD 0726843 (Figure 4):



Figure 4 - The red circle shows that there was no clearance adjustment as required on the mechanical drive lever.

On 02MAY2021, after the occurrence, the adjustment was carried out in the aforementioned activation lever, as stated in OS 210628-002 of 17APR2021. On that occasion, it was verified that the clearance was adjusted to approximately 4 mm, according to the orientation contained in the MMA 25-31-03-822.

Make sure that the clearance "F" between the housing unit (32) of the release unit (13) and the lever is lower than or equal to 4mm (.157in).

On the same occasion, it was noticed that the cable conduit for the mechanical activation of the hook was frayed (Figure 5).



Figure 5 - The red circle shows the clearance of approximately 4 mm between the lever and the housing unit. The yellow arrow shows frayed mechanical drive cable conduit (PN 704A31-813009).

As a corrective measure, the replacement of PN 704A31-813009, in question, was provided.

On the same date, checks and analysis of the electrical system for continuity, isolation and electromagnetic interference in the cabling (PN 332A673846000) were carried out, keeping the hook actuation switch both in the OFF and SLING positions, as well as checking the wire cargo hook mass according to the WDM 25-31-601/602, concerning the electrical/mechanical actuation of the cargo hook. In these tests, no discrepancies were identified.

In addition, the cargo hook opening mechanical actuation set was checked for its correct operation, and it was made the setting to the adjustment nut of the mechanical opening of the hook.

According to SB No. EC225-25-122 - Reversing T-3.8 Sling Hook Revision 1, of 03MAR2019, from Airbus Helicopters, the installation of the cargo hook on the aircraft followed two distinct patterns, namely:

- one for aircraft manufactured before 2016, i.e: PRE MOD (Pre-Modification); and
- one valid for aircraft manufactured after 2016, i.e: POST MOD (Post-Modification) (Figure 6).

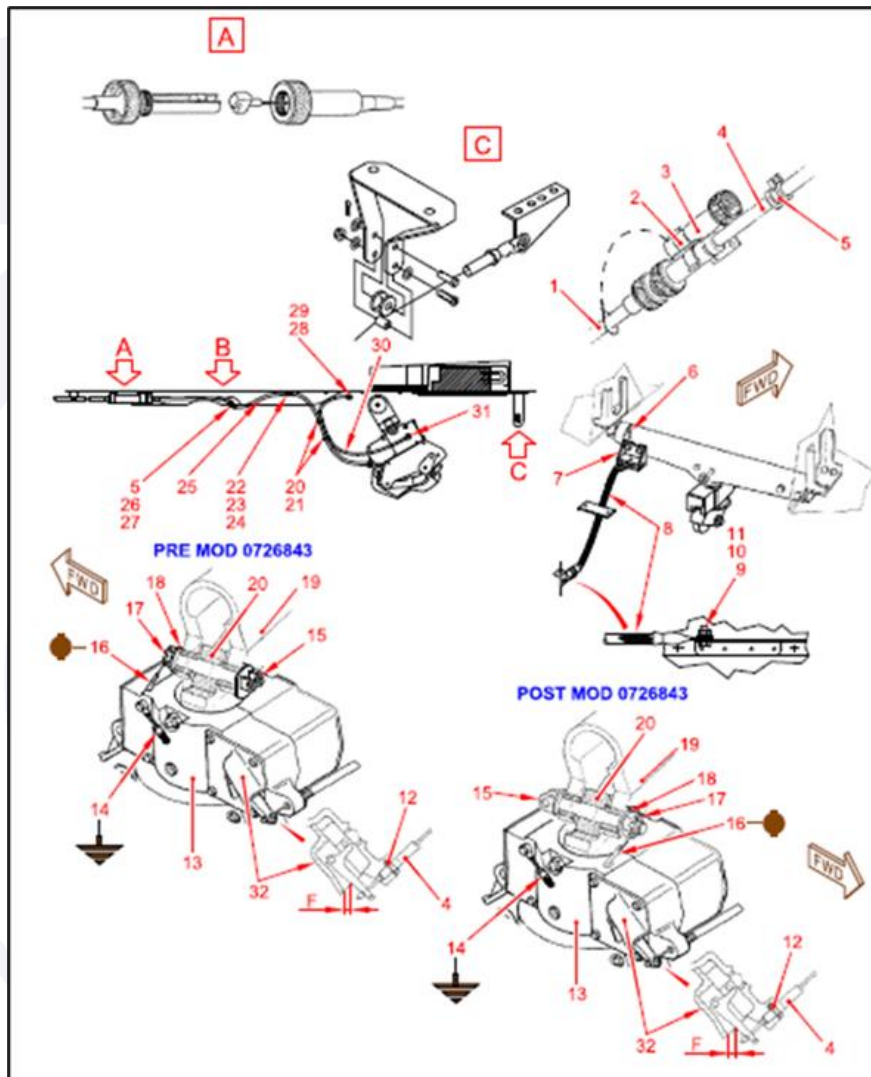


Figure 6 - Difference between the types of installation of the cargo hook opening mechanical actuation set. Source: SB No. EC225-25-122-Reversing T-3.8 Sling Hook.

This aircraft was manufactured in 2012 and was configured in the PRE MOD version.

It was found that both the electrical supply wiring and the mechanical control cable used for the cargo hook installation had specifications for the PRE-MOD configuration. However, the installation took place for the POST MOD (0726843) configuration, in disagreement with the provisions of the SB EC225-25-122.

However, after analyzing the MMA 25-31-03-061- Removal - Installation of Support Beam and Release Unit - 3.8 - Tonne Capacity Sling, the Investigation Team understood that the only demonstration regarding the correct way of installing the electrical wiring of

the cargo hook release unit, as well as the mechanical drive system, was presented in sub-task 25-31-03-431-002, item 3.4 - Installation of the release unit POST MOD 0726843.

1.7 Meteorological information.

The weather conditions were favorable for the flight.

1.8 Aids to navigation.

Nil.

1.9 Communications.

Nil.

1.10 Aerodrome information.

The occurrence took place out of the Aerodrome.

1.11 Flight recorders.

The aircraft was equipped with a flight data recorder, CVFDR type, manufactured by Honeywell, SN ARCOMB-00540.

The CVFDR was sent to the LABDATA facilities at the CENIPA in Brasília - DF, to read the communications made by the crew and to obtain the flight data.

In addition, analyzes of the data available on the M'ARMS card were performed.

The Aircraft data recording equipment did not record the activation of the cargo hook opening system (regular and emergency system).

1.12 Wreckage and impact information.

Nil.

1.13 Medical and pathological information.

1.13.1 Medical aspects.

No evidence was found that problems of physiological nature could have affected the flight crew's performance.

1.13.2 Ergonomic information.

Nil.

1.13.3 Psychological aspects.

No evidence was found that problems of physiological nature or incapacitation could have affected the flight crew's performance.

1.14 Fire.

There was no fire.

1.15 Survival aspects.

Nil.

1.16 Tests and research.

Continuity, isolation, and electromagnetic interference tests were performed on the PN 332A67384600 wiring.

The tests were carried out by personnel accredited by the manufacturer and accompanied by an accredited representative of the BEA and by investigators from the SERIPA VII.

The hook activation switch was tested in the OFF and SLING positions, and the cargo hook ground wire was checked, according to the WDM 25-31-601/602, p. 1001 - Test of the Revolving Cargo Sling Release Mechanism, PN AS21-10 and SN 361.

The tests were performed according to the CMM 25-81-99-I, 28FEB2020. Initially, the electrical resistivity was analyzed, and it was found that all the measured values were in accordance with those required by the manual.

Then, the operation of the lights was verified, seeking to assess whether the checks made on the hook had their correspondence with the lighting of the respective lights in the control box used without any discrepancy being detected.

In the Inspection and Check item, all the analyzed steps corresponded to the parameters required by the CMM.

Finally, dimensional checks were performed, and it was found that all measurements were under what the CMM predicted.

However, it was found that the equipment had been installed in disagreement with the recommendations of SB No. EC225-25-122 - Reversing T-3.8 Sling Hook - Revision 1, of 03MAR2019.

1.17 Organizational and management information.

OMNI Air Taxi had administrative and operational headquarters in Rio de Janeiro - RJ as well as an Operations Base focused on the External Load operation in Porto Urucu and Carauari, both in Amazonas, from where it carried out passenger and cargo transport operations.

The company operated in accordance with the rules established by the RBAC No. 135 and RBAC No. 133, Operation of Rotary-Wing Aircraft with External Loads.

For this reason, the aircraft was certified to conduct operations with External Cargo in the aircraft/cargo combination, as "B and D" classes.

According to its EO, issued by the ANAC, its fleet consisted of nine helicopters from three different manufacturers: Agusta, Airbus and Sikorsky. In view of this, the Operations Department developed a SOP for each model.

As for the operation at the Urucu and Carauari Bases, the crews used to work on a fortnightly rotation, with exchanges carried out in Carauari.

Due to the interruption of the contract involving the Rosneft company with the contracted operator OMNI Air Taxi, activities were suspended for approximately one year and the consequent suspension of the crews and support teams contracts.

With the reintegration of the crew and the resumption of operations in Carauari, the company, in order to ensure that the qualifications, training and exams were valid, assigned a SIC for that mission to perform an adaptation flight on the aircraft engaged in the external load operation.

The first day of activities resumption was marked by this incident.

1.18 Operational information.

The aircraft was within the weight and balance limits specified by the manufacturer at the time of the occurrence.

It was an external load transport flight weighing approximately 1,800 kg, which was connected to the aircraft's cargo hook.

During the framing of the final approach for the Fortaleza Base, approximately 1 km to the landing, there was the uncommanded jettisoning of the external load.

The pilots did not notice any alarm or warning light on the instrument panel, which made it impossible for the crew to identify any failure in the hook system.

The cargo fell into a forest region and was not located. The aircraft landed normally at its destination.

In the interviews, the crewmembers were emphatic in stating that they did not carry out the command to jettison the load and did not even have their hands on the flight control, given that the autopilot was engaged in the functions: altitude maintenance (ALT HOLD), maintenance of indicated speed (IAS HOLD) and attitude maintenance (ATT HOLD).

According to item 2 Imperative Pre-Operational Checks, Section 9.1 - Guidance For Cargo Sling Operations of the Complementary Flight Manual, the following items should be observed:

2.1 Helicopter condition

In addition to the usual examination of the helicopter, the release unit must be carefully examined, and the mechanism checked for correct release operation.

2.2 Condition of sling equipment

The nets, strops and slings must be examined thoroughly. Any worn or frayed components are to be discarded.

The cables, strops and shackles must be capable of carrying three times the maximum anticipated load.

In general terms, a thorough examination of both the unit and the operation of the release mechanism was recommended.

Likewise, nets, strops, and slings should be scrutinized thoroughly. Any worn components should be discarded. Cables, slings, and hooks should be capable of carrying three times the maximum intended load.

For the operation with external load, the Complementary Flight Manual recommended, among other aspects, that the take-off should be performed vertically, avoiding dragging the load along the ground or hitting any obstacle.

During the flight, if the load oscillated, it was necessary to reduce the speed.

The approach should be made headlong into the wind, with a gradual speed reduction, with the aim of hovering high enough above the ground to eliminate the risk of dragging the load.

Finally, item 5 - Cargo Ring Size Rule, Section 9.1 - Guidance For Cargo Sling Operations of the Complementary Flight Manual guided that:

Particular care must be exercised when attaching a load to the cargo hook.

It is the responsibility of the operator to assure the cargo hook will function properly with each rigging.

1.19 Additional information.

Nil.

1.20 Useful or effective investigation techniques.

Nil.

2. ANALYSIS.

It was an external cargo transport flight weighing approximately 1,800 kg, which was connected to the helicopter's cargo hook.

During the framing of the final approach for the Fortaleza Base, in a region of dense vegetation, approximately 1 km from the landing, there was an uncommanded jettisoning of the external load.

After the cargo was released, the crewmembers tried to identify the place of the fall and write down the coordinates, which was not possible due to the dense vegetation (forest).

The pilots did not notice any alarm or warning light on the instrument panel, which made it impossible for the crew to identify any failure in the hook system.

The pilots stated that they did not carry out the command to jettison the load, and they did not even have their hands on the flight control, given that the autopilot was engaged in the ALT HOLD, IAS HOLD, and ATT HOLD functions.

Considering that the aircraft's data recording equipment did not record the activation of the load hook opening system (regular and emergency system), it was not possible to find evidence that there was inadvertent activation of the load jettisoning button by the crew.

It was found that both the electrical supply wiring and the mechanical control cable used for the cargo hook installation had specifications for the PRE-MOD configuration. However, the installation took place in the POST MOD configuration (0726843), in disagreement with the provisions of SB EC225-25-122.

According to tests and research performed, no damage or abnormal wear was found that could have caused the hook to open without command.

On the other hand, it was found that the primary ring used to connect the load to the respective hook was out of the dimensions specified by the manufacturer. The mandatory ASB 04A004, dated 12MAY2009, indicated that the internal diameter of the ring should be 120 mm. However, the one being used in the incident flight had 160 mm.

Such difference, according to the document, could, in some cases, lead to the loss of the external load because they are not properly adapted to the size of the hook.

Likewise, a possible rupture of the primary ring, which connected the lifting set to the cargo hook, cannot be ruled out.

It was found that all the mandatory inspection documentation of the rings was updated, but as it was not possible to find the load or the lifting set, it was not possible to carry out any examination of the material.

In spite of the fact that the documentation referring to the inspections is updated some nonconformities were found, such as: the mechanical actuation lever did not have a clearance adjustment as required for its installation, as provided for in MMA 25-31-03-061, sub-task 25-31-03-431-001, 3.3 Installation of the release unit PRE MOD 0726843 and the framing of the mechanical hook drive cable conduit.

Finally, the fact that the load and the rings were not located made further analysis impossible, leaving doubts as to the real reason that led to the uncontrolled detachment.

3. CONCLUSIONS.

3.1 Facts.

- a) the pilots had valid CMAs;

- b) the pilots were qualified and had experience in the type of flight;
- c) the pilots had valid EC25 type aircraft Ratings;
- d) the aircraft had a valid CA;
- e) the aircraft was within the weight and balance limits;
- f) maintenance records were updated;
- g) the weather conditions were favorable for the flight;
- h) during the framing of the final approach for the landing, there was the uncommanded jettisoning of the external load;
- i) the cargo was not located;
- j) the landing was carried out safely;
- k) it was found that the primary ring used to hook the load measured 160 mm, that is, it was out of the 120 mm specifications, established in the ASB No. 04A004, of 12MAY2009;
- l) the aircraft was not damaged; and
- m) all occupants left unharmed.

3.2 Contributing factors.

- Aircraft maintenance – undetermined.

The ring used to attach the load to the aircraft hook was not within the measures recommended by the ASB EC225, No. 04A004, Limitations - SIREN Load Release Units: load jammed on the cargo hook in the open position, Revision 0, 12MAY2009, from Eurocopter An EADS Company.

Likewise, it was also verified that the provisions of item 5 - Cargo Ring Size Rule, Section 9.1 Guidance for Cargo Sling Operations, of the Complementary Flight Manual, which also addressed the dimensions of the ring that should be used for the type of hook installed on the helicopter.

The use of rings not properly adapted to the size of the hook could, in some cases, lead to the loss of the external load.

- Managerial oversight – undetermined.

It is inferred that there was an inadequate supervision of the maintenance services execution activities when it was allowed to use rings with dimensions out of those recommended by the Alert Service Bulletin EC225, nº 04A004, Limitations - SIREN Load Release Units: load jammed on the cargo hook in the open position, Revision 0, dated 12MAY2009, by Eurocopter An EADS Company.

It was found that both the electrical supply wiring and the mechanical control cable used for the cargo hook installation had specifications for the PRE-MOD configuration. However, the installation took place in the POST MOD configuration (0726843), in disagreement with what was prevised in the SB EC225-25-122.

Thus, it cannot be ruled out that these nonconformities have contributed to the uncommanded jettisoning of the external load.

4. SAFETY RECOMMENDATION.

A proposal of an accident investigation authority based on information derived from an investigation made intending to prevent accidents or incidents and which in no case has the purpose of creating a presumption of blame or liability for an accident or incident. In addition to

safety recommendations arising from accident and incident investigations, safety recommendations may result from diverse sources, including safety studies.

In consonance with Law n°7565/1986, recommendations are made solely for the benefit of the air activity operational safety, and shall be treated as established in the NSCA 3-13 “Protocols for the Investigation of Civil Aviation Aeronautical Occurrences conducted by the Brazilian State”.

Recommendations issued at the publication of this report:

To Brazil’s National Civil Aviation Agency (ANAC):

I-055/CENIPA/2021 - 01

Issued on 03/23/2023

Work with OMNI Air Taxi S.A. (COM 0311-02/ANAC) to demonstrate that the processes related to the qualification and training of personnel, management supervision, and quality control of the services performed meet the requirements established in the applicable regulation.

5. CORRECTIVE OR PREVENTATIVE ACTION ALREADY TAKEN.

None.

On March 23th, 2023.