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April 17, 2008

Honorable Jim Oberstar
2365 Rayburn HOB
Washington, D.C. 20515

SUBJECT: Testimony of Mary Rose Diefenderfer, FAA Whistleblower (Alaska Airlines)

Dear Honorable Oberstar:

My testimony herein is in reference to the April 3, 2008 FAA whistleblower testimony before United States Transportation and Infrastructure Committee, headed by yourself and Representative DeFazio, and how that testimony directly relates to the FAA lack of oversight of Alaska Airlines and the ***Alaska Airlines 261 crash*** in January 2000.

I believe it is necessary to bring this matter to your attention because the circumstances are similar, but as a FAA whistleblower, I lost my career. However, the high ranking FAA management personnel are still in positions of authority over Alaska Airlines, which I believe is a great detriment to public safety to this day. I respectfully request your assistance in investigating this matter, including the illegal activities of FAA management, and bringing this matter to a conclusion with my career reinstatement.

I will draw a comparison between the inspector testimony during the April 3, 2008 hearings, where inspectors described the actions of Southwest Airlines and FAA Southwest Region management, with the actions of Alaska Airlines and FAA Northwest Mountain Region management (headed by Mr. Bradley Pearson) between 1991 and 2003. The story is much the same. However, people died in the case of Alaska Airlines.

My comparison will show that Alaska Airlines' lack of regulatory compliance and negative safety culture was brought to the attention of FAA management in Seattle, and was not only ignored, but a systematic campaign of retaliation was initiated against those inspectors, including me, who spoke up for the flying public. I believe that if our warnings had been heeded by FAA management, 88 people might not have died on that Alaska Airlines flight in 2000. The real tragedy is that Mr. Pearson and other FAA managers were never held accountable for their retaliatory actions against inspectors prior to the accident, and for their misleading statements about the whistleblowers and the Alaska Airlines culture during the NTSB testimony.

I served as FAA Principal Operations Inspector (POI) in Seattle overseeing Alaska Airlines from 1993 through 1997 (Northwest Mountain Region, Seattle Flight Standards District Office). My duties were as primary Flight Operations Inspector with direct responsibility for Alaska Airlines legal approvals and operations surveillance program. I also had oversight responsibility for three other inspectors, who reported their findings to me for action. Subsequently, from the end of 1997 until the end of 1999, I worked for the FAA in another office after being suddenly reassigned for whistleblowing. I was forced out of the FAA two months before the crash.

As POI, I found a highly dangerous safety culture within Alaska Airlines. It was one of defiance of regulatory authority, especially the FAA, and a culture that appeared to lack any consideration for safety. The culture seemed to be one of "get the job done no matter how illegally you have to do it". There was also a strong culture among mid-level and senior Alaska Airlines management that false complaints against FAA inspectors would keep the FAA from finding deficiencies because inspectors would be reassigned, or at least restricted.

I reported my Alaska Airlines safety findings, as well as the findings of the three inspectors who reported to me, through the FAA chain of command, but our warnings were not heeded. In fact, FAA management began to ostracize me, hindered me from making future reports and correcting problems, sent me to "reprogramming" sessions disguised as a customer service initiative, reassigned me, escalated the retaliation, and ultimately forced me out of the agency though bogus disciplinary actions at the end of 1999. My career was virtually ended for trying to protect the flying public. The three other inspectors experienced similar treatment and two were reassigned from their positions- just like the inspector group overseeing Southwest Airlines.

Ultimately, in May 1997, three Alaska Airlines inspectors and I made a whistleblower report to the DOT Office of Inspector General in Seattle, which focused on FAA management hindered us from performing our jobs and pandered to Alaska Airlines. We expressed our concerns that Alaska Airlines was headed towards a major disaster, and that FAA management's actions were going to be a contributing factor. I also made reports to FAA Security, the FBI, and the NTSB (following the accident). The various parties were warned of an impending disaster if conditions didn't change.

Two months after I was forced out of the FAA, Alaska Airlines 261 crashed off the coast of California killing 88 people. The NTSB ultimately found that the FAA Seattle Office contributed to the crash by its lack of oversight (the report is online at the NTSB website). I believe that if the FAA would have listened to the Alaska Airlines inspector team, those 88 people would still be alive.

During the Transportation and Infrastructure hearing, the ***FAA inspectors overseeing Southwest Airlines*** testified to the following conditions great detail:

1. Regulatory and safety deficiencies at Southwest Airlines
2. Attempts to correct the deficiencies were thwarted by FAA management
3. A culture in the FAA office overseeing Southwest Airlines of "No see, no tell"
4. FAA management held "customer relations" above safety and regulatory considerations, even forcing inspectors into Customer Service Initiative (CSI) meetings
5. Southwest Airlines used this CSI process to complain about inspectors who found violations and have them reassigned
6. The inspectors who found problems had their careers threatened, faced disciplinary action, were harassed, and were reassigned to other jobs

Please take a moment to review and compare the almost identical treatment in chronological order of ***FAA inspectors who oversaw Alaska Airlines*** from 1991-2000, keeping in mind that the current Division Manager, Brad Pearson, was in charge throughout those years. The <u>underlined text is FAA/airline action</u> that is similar to what inspectors reported in the hearing:

1. 1991/1992- Robert Lloyd is Principal Operations Inspector. He finds Alaska Airlines <u>falsifying pilot training records</u> for required simulator windshear training. He initiates an enforcement investigation on the case. <u>He is harassed</u> by FAA management for his findings and ultimately is <u>told to drop the case</u> after his investigative <u>evidence package disappears</u> from his desk while meeting with the Division Manager, a meeting which the Division Manager called regarding the falsification case.
2. 1993- I (Mary Rose Diefenderfer) am Principal Operations Inspector. I find <u>falsification of pilot training records</u> and make a report to both FAA Security (due to the criminal nature of the case) and FAA Flight Standards management. <u>I am harassed, have my FAA</u>

required medical certificate threatened, have my career threatened, and I'm ultimately reassigned to another office. I file an EEOC case and I'm returned to the POI position. (Falsification was proven and action taken)

3. 1994-1997- I, as well as other inspectors who work for me, warn FAA management that the safety and regulatory compliance culture at Alaska Airlines is degrading and could result in an accident. We are ignored, and enforcement paperwork is "lost" at the management level.
4. 1995- Alaska Airlines management is forcing pilots to make dangerous and illegal instrument approaches to airports in the State of Alaska. I fly to Dutch Harbor to investigate and find basis for an enforcement case. FAA management restricts me from investigating and traveling to Dutch Harbor in the future.
5. 1996- Alaska Airlines threatened inspectors with their jobs if they don't back off of enforcement actions.
6. Alaska Airlines attempts to have inspectors removed numerous times between 1994-1996 through various types of complaints.
7. 1997- Inspectors are finding more violations at Alaska Airlines, so the airline escalates complaints about inspectors. Two violations appear to be falsification of records, a criminal offense. Inspectors investigate and find cause to pursue legal action.
8. Alaska Airlines Chief Pilot admits to making false entries in the pilot training records. He is removed from his job. The FAA supervisor, Phil Hoy, begins a campaign against the inspectors to intimidate them into ignoring the violation.
9. I attempt to change Alaska Airlines record keeping requirements so it's easier to spot falsification of records but I'm not permitted to do so after complaints by Alaska Airlines VP of Flight Operations.
10. The supervisor, Phil Hoy, restricts the inspectors from gather evidence, including restricting the inspectors from doing unannounced spot checks.
11. FAA Supervisor, Phil Hoy, informs the Alaska Airlines VP of Flight Operations of the details and status of the inspector's investigations during the investigations.
12. Alaska Airlines refuses to provide information to the inspectors during investigations. Phil Hoy does not support the inspectors.
13. After inspectors find violations, Phil Hoy tells the airline to investigate their own violations and determine if, in fact, a violation occurred. This is contrary to FAA regulations and the Voluntary Disclosure Program.
14. Alaska Airlines VP of Flight Operations informs the FAA Supervisor, Phil Hoy that he is going to do everything in his power to get rid of inspectors who have regulatory violation findings. He follows up with false accusations, which the inspectors must defend.
15. Phil Hoy, the supervisor, informs inspectors that he believes what the Alaska Airlines VP tells him, and not what the inspectors report.
16. Phil Hoy informs inspectors that the inspectors are too hard on the airline and he feels compelled to stop them. Career threats are implied.
17. Phil Hoy does not allow inspectors to send Alaska Airlines letters of investigation. This means that inspectors are not allowed to open case files on violations they discover.
18. Alaska Airlines CEO, John Kelly, informs FAA supervisor, Phil Hoy, that if FAA violation penalties were over $50,000 he would sue the FAA (penalties over $50,000 are posted on the FAA's website). All future sanctions were below $50,000.
19. Two pending maintenance violations/sanctions for the airline knowingly flying with leaking fuel tanks and cracked landing gear are dropped below $50,000. Inspectors originally recommended sanctions of over $1 million dollars because the airline knew of the problems, but flew the aircraft anyway.
20. The supervisor, Phil Hoy, and Seattle Flight Standards District Office Manager, Marlene Livack, place inspectors in "facilitated meetings" to make inspectors understand

customer service (at Alaska Airlines request to apparently force the inspectors to pander to the airline. This is similar to the FAA and Southwest Region's Customer Service Initiative)

21. Alaska Airlines VP of Flight Operations tries to pressure FAA management into shortcutting required program approval processes by making complaints that inspectors are holding up approvals. The supervisor and office manager imply threats against the inspectors, and badger inspectors in required "facilitated" meetings.
22. Other Alaska Airlines inspectors and I report Alaska Airlines safety/regulatory deficiencies, and FAA management interference to the Division Manager (Brad Pearson) but he does nothing to address the illegal activity. Rather, he supports the airline and the District Office management by his threats that "something in the relationship (inspectors and Alaska Airlines) had to change, or else." "Or else" was a threat that Pearson fulfilled by supporting the harassment and removal of inspectors.
23. May 1997- Four Alaska Airlines inspectors, including me, make an official whistleblower complaint to the Office of Inspector General in Seattle, citing management harassment and interference of FAA inspectors in making safety findings and pursuing violations.
24. Alaska Airlines is making illegal instrument approaches into the Reno Airport, but my attempts to stop them are thwarted by my supervisor, Phil Hoy, and office manager, Marlene Livack.
25. After writing numerous letters to Alaska Airlines management officials in 1997 citing safety and cultural problems, I am reassigned with no notice to another office.
26. Several inspectors who worked for me and who found safety violations are told by the supervisor that "their careers would be better served in another section". They are transferred from Alaska Airlines oversight.
27. The one of the two potential falsifications of records violations is closed with no action and the other simply disappears from the FAA database.
28. June 1997- Alaska Airlines mechanic, John Gustafson, writes a letter to the Seattle FAA office citing numerous specific instances of Alaska Airline management making false entries in aircraft maintenance logbooks. The FAA does nothing.
29. 1997/1998- My husband's supervisor, Tom Anderson, threatens my husband with loss of his career if he "didn't get his wife under control".
30. Supervisor Phil Hoy threatens inspector, Les Martin, with career loss if he didn't request a transfer out of the Alaska Airlines section.
31. 1998- John Liotine, an Alaska Airlines mechanic, makes a disclosure of falsification of records by his supervisor to the FAA. FAA officials didn't believe him then worked with Alaska Airlines to fire this employee and allegedly cover up the violations. ***The record that was falsified by the supervisor was John Liotine's order to change the jackscrew on the same aircraft that crashed in January 2000 due to the jackscrew failure. If the FAA had believed the inspectors and John Liotine, 88 people would be alive today.***
32. 1998- The FBI begins a criminal inquiry into falsification of maintenance records by Alaska Airlines. Finally certificate action is taken against certain Alaska Airlines management officials in the maintenance department and a small fine is levied against the airline (under $50,000).
33. 1999- I submit a safety report and recommendation about Alaska Airlines continuing to make illegal approaches to the Reno airport. My attorney also makes a press report about lack of whistleblower protections for FAA employees under the FAA Excepted rules. The FAA escalates their harassment of me.
34. I am assigned to a supervisor, Mike Kelly, who has a criminal arrest record of abuse of females. FAA Division Manager, Brad Pearson and other managers supported this supervisor to the extent that FAA officials paid his bail and pleaded on his behalf to the

court. His charges were then dropped from a felony to a misdemeanor, and because of the FAA's testimony on his behalf, he served jail time at night and worked at the FAA during the day.

35. I'm disciplined by Mike Kelly for my attorney's contacts with the press regarding whistleblower protections
36. FAA officials lie in sworn statements to the US Attorney about me.
37. I am forced out on Leave Without Pay (LWOP) to try to preserve my career and remove myself from Mike Kelly's abuse. I'm on LWOP from April 1999 until December 1999.
38. I'm harassed at home on LWOP by Mike Kelly, and eventually ordered back to work for him after continuing my whistleblower reports about the safety of Alaska Airlines and Mike Kelly's abusive behavior.
39. Although I'm on approve LWOP, I'm placed on AWOL by the FAA after making a complaint about Mike Kelly's abusive and retaliatory behavior towards me. I'm given a 14 day suspension notice.
40. I'm turned down for transfers to safer offices and regions.
41. I'm sent for psychological evaluation.
42. I take constructive discharge in late November 1999.
43. Mike Kelly gets a promotion.
44. Meanwhile, the remaining operations inspectors overseeing Alaska Airlines are afraid to find violations, presumably because they also fear retaliation. The inspector mantra now seems to be, "No see, no hear" airline deficiencies. Very few violations are found.
45. January 2000, Alaska Airlines flight 261 crashes, the FAA is found negligent through lack of proper oversight. There were no repercussions for FAA management.
46. After the accident, FAA Headquarters inspectors spend months trying to bring Alaska Airlines up to standards. However, Alaska Airlines continues its resistant attitude against the FAA and Federal Regulations.
47. The new Principal Maintenance Inspector, Bill Whitaker, is removed from his position after he attempts to make positive safety changes within Alaska Airlines after the crash of flight 261.
48. In the late 1990s and prior to the Alaska Airlines crash, Tom Stuckey (The same Tom Stuckey from the April 3, 2008 hearings) was in a position of leadership at FAA Headquarters. He was instrumental in the retaliation against inspectors who had oversight of Alaska Airlines during the late 1990s.
49. In 2003 the FBI again opens a fraud investigation against Alaska Airlines.

Although these bullet points are abbreviated and not all inclusive, they demonstrate an egregious, concerted, and ongoing effort on the part of FAA Flight Standards Northwest Mountain Region management to protect Alaska Airlines and destroy inspectors doing their jobs.

Between 1991 and 2000, three Principal Inspectors (Bob Lloyd, Bill Whitaker, and me) reported safety deficiencies and were harassed and/or reassigned. In 1997, three of the four inspectors who made a safety report to the DOT OIG were reassigned (Jewett Gibson, Lester Martin, me). The fourth inspector (Steve Franklin) was all but silenced through disciplinary actions.

All the indicators described in the Inspector Handbook (Order 8400.10) were present between 1991 and 2000, and pointed to a future major accident, but FAA management did nothing except restrict, harass and remove the reporting inspectors and retaliate against me to my breaking point. What kind of message does this send to a regulated airline and to the inspectors who are supposed to be the regulators?

All these events are documented and have been brought to light by the Seattle PI, Seattle Times, USA Today, Newsweek and other publications at one time or another, yet FAA Headquarters and the FAA Administrator did nothing except support Brad Pearson's actions.

The illegal activities of Seattle FAA management are similar to the illegal activities of Dallas FAA management. They are also similar to the retaliation that Mark Lund (FAA inspector assigned to Northwest Airlines) recently faced for whistleblowing. He reported it to his Congressional representative and was protected.

These illegal activities appear to be a typical pattern in the FAA, but in the case of Alaska Airlines, the guilty FAA officials were never held accountable for the accident and deaths. Although Brad Pearson misled the NTSB during the accident inquest, he still leads the Northwest Mountain Region in Seattle, which means he still oversees Alaska Airlines. When the cause of the disease is still in place, how can safety changes ever be accomplished? Furthermore, what is occurring today behind the scenes at Alaska Airlines that the public needs to fear? Who is looking into the Seattle FAA culture and who is protecting the flying public? Certainly by their track record, Brad Pearson and his management team can't be counted on to do the job.

In January 2000, the flying public paid a high price for the Seattle FAA's lack of oversight, and I've paid dearly for blowing the whistle on the malfeasance of Northwest Mountain Region officials who threatened and hindered inspectors for their findings. I've lost my career, my retirement, my health insurance, and I've spent the last 10 years in the legal system trying to gain my career back while Brad Pearson and his management team continue to be paid high salaries, and continue to mislead the public, the courts, the NTSB, and Congress.

FAA management calls whistleblowers like me "problem employees" and disgruntled employees". We are neither; we are worried, conscientious employees who love our jobs and feel a calling to protect the public. In my case, as Principal Operations Inspector responsible for signing the Airline's legal operating documents, I risked potential legal action if I was derelict in my duties to the flying public. I was between the proverbial rock and a hard spot, which subjected me to being lied about and set up for disciplinary action by FAA management for doing my job. And it never stops. The FAA management is still making a concerted effort to discredit my diligent work through their untrue testimony in recent hearings.

My attempts to gain my career back have been an exercise in frustration. Due to the changes in the 1996 FAA Reauthorization Act, the FAA was removed from Title 5 and became an Excepted organization, meaning they could create their own personnel rules. One of the inadvertent errors of this change was that FAA employees were no longer covered by the Whistleblower Protection Act. For this reason, whistleblowers (like me) between 1996 and 2000 fell through the cracks and lost their careers because there were no protections or remedies available to them. Making a safety and regulatory organization like the FAA an Excepted organization was a huge failure and setback for public safety. The Alaska Airlines crash has clearly demonstrated that failure.

Sometime around 2000, Congress reinstated whistleblower protections, which allowed me to restart my legal proceedings. In 2006 and 2007, I had a Merit Protection Board Hearing and an EEOC hearing, both administrative hearings. Unfortunately, during the hearings the FAA was successful in severely limiting the scope of our testimony (timeframes and witnesses) to benefit their case and limit my ability to demonstrate a pattern of illegal activity that caused the accident. We've not had a fair hearing to date because we've been restricted from fully telling our story-the TRUTH.

However, the facts remain. I blew the whistle between 1993 and 1999 and I lost my career, but 88 innocent passengers and crew died anyway on Alaska flight 261.

That testimony I set forth above is true and can be substantiated through documents and witnesses.

Therefore, keeping the Southwest Airlines inspector testimony in mind, and my testimony herein, I respectfully request your assistance in two areas:

1. I would like my career reinstated with the FAA, just as those Southwest Airlines and Northwest Airlines inspectors were protected and able to return to work after an identical situation. Along with that, I would like the FAA to make me whole for the past years that I suffered away from my career. I have not been able to secure employment in my field and I can only guess that the FAA has seen that I do not.
2. Brad Pearson must be held accountable for his malfeasance and the deaths of 88 people in the crash of Alaska Airlines flight 261.

I recognize that this is a very big request, but I have suffered mentally, physically, and financially for years because I fulfilled my duties to the public as a FAA inspector under the law, while unscrupulous FAA management in Seattle allowed the degradation of safety and the crash of Alaska Airlines flight 261 to occur. It is time this situation is corrected and the real culprits are held accountable for their egregious and illegal activities.

I can be contacted at 206-244-6099 for more information or for personal testimony. I appreciate your time and attention in this matter and I look forward to hearing from you.

Sincerely,

Mary Rose Diefenderfer
Ex-FAA POI, Alaska Airlines Section

Attachments:

2001 Letter to President Bush
2003 Letter to President Bush

Statement of Mary Rose Diefenderfer, ex-POI Alaska Airlines from May 1993-June 1997.

This statement is meant to assist the NTSB in their investigation into the crash of ASAA 261, and any contributing factors caused by lack of FAA oversight, or interference by FAA management. This statement is not to be given to anyone from Alaska Airlines.

My experience background:

Graduate B.S. Aeronautical Science, Embry Riddle Aeronautical University
February 1978-October 1985, Texas International/Continental Airlines DC-9 pilot
July-1988-November 1999, FAA Aviation Safety Inspector, including the following positions:

- Geographic air carrier inspector
- A-320 national resource
- Geographic Section Supervisor
- DC-9 Aircrew Program Manager, Midway Airlines
- Assistant POI, Alaska Airlines
- Supervisory POI/POI Alaska Airlines
- Regional Air Carrier Specialist, Technical Standards Branch

Certificates, Rating, Flight Hours:

Airline Transport Pilot, DC-9, A-320, multi-engine
Commercial, Single Engine Land and Sea
Private, Glider
Flight Engineer, Turbojet
Certified Flight Instruct, Single Engine Land, Instrument
Basic, Advanced, and Instrument Ground Instructor
Approx. 5000, 4000 in Part 121 operations

Awards:

FAA Distinguished Service Award
Star Quality Award
Several performance awards

Current Position: Vice President of Safety & Regulatory Compliance at Pro Air, Inc.

General Statement:

The compliance attitude being demonstrated by Alaska Airline maintenance currently is not unexpected. This attitude was first exhibited in Alaska Airlines Flight Operation years ago. FAA management promoted this attitude through interference with inspectors. It is only a natural progression that the attitude spread to maintenance, while the airline enjoyed the protectionism of the FAA.

I am the previous FAA Principal Operations Inspector (POI) for Alaska Airlines. I have strong evidence and history, which strongly suggests a company attitude at Alaska Airlines that could have been a contributor to this accident. This attitude includes failing to not write up mechanical discrepancies so to "get the job done", and a history of falsification of records, and several instances of non-compliance with FAA Approved training programs (including similar reoccurring events).

I can also show interference by FAA management officials, all the way to FAA Headquarters, which helped to promote this company attitude. I have evidence of FAA management interference in inspector investigations, FAA making deals with ASAA to "fix" the inspectors, FAA management ordering inspectors not to be "too hard" on ASAA, implied threats, and disciplinary actions as a result of ASAA complaints.

I can show that Alaska Airlines regularly made complaints about the inspectors to FAA management, usually in conjunction with inspectors filing violations. I can show that ASAA management was involved in making false allegations against inspectors during FAA Security investigations. I can show that FAA management bowed to ASAA's demands to "fix inspectors", and that FAA management sought ASAA's input as to what actions should be taken to "fix the inspectors".

I held the ASAA POI position from May 1994 through June 1997. Previous to that, I was the Assistant POI (APOI) for Alaska Airlines, acting in the position of POI. Hence, I have about 5 years experience overseeing Alaska Airline, I am familiar with the attitude of the pilots, the company "unwritten philosophies", the relationship between the FAA management and the airline, and the violation history of the pilots and company.

The reason for my statement is to make you aware of some of the history of the issues I encountered as POI for Alaska Airlines. You should also be aware of the relationship between FAA Flight Standards management in the Northwest Mountain Region and FAA Headquarters, and Alaska Airlines. I believe the FAA contributed to the Alaska Airlines Flight 261 tragedy.

Late 1998/early 1990- Mr. Edward Duchnowski is FAA POI for Alaska Airlines (ASAA). He worked directly for Mr. William Baldwin, Previous POI for ASAA. Mr. Baldwin historically has the attitude that the FAA's customer is ASAA. Mr. Duchnowski interviewed and accepted a management position with ASAA while he was the POI. He continued to have oversight of ASAA after accepting a position with ASAA. FAA management overlooked this conflict of interest. The matter was brought to the attention of FAA Legal and FAA Security at a later date, but no action was pursued.

During the 1991 timeframe, I was called by Ed Duchnowski to conduct type-rating rides at Alaska. Ed was the POI. In Seattle, he told me that he had been hired by Alaska Airline and was going to work in the near future.

My husband, Glenn, interviewed for the POI position, which Duchnowski was vacating. Duchnowski also told Glenn that he was going to work for Alaska Airlines. Duchnowski was still the POI.

Mr. Robert Lloyd becomes POI approximately 1990/91. He continuously has problems with ASAA lying to him about various regulatory and safety issues. One lie was the status of ASAA windshear training. ASAA informed Lloyd several times that ASAA was performing wind shear recovery training in the MD-80 simulator in Long Beach, CA. By coincidence, a Long Beach inspector called Lloyd to tell him that the simulator

was not approved for wind shear recovery training because the wind shear instruments were not installed in the simulator. This scenario was typical from ASAA. (Lloyd has detailed diaries to verify). He also has problems with ASAA management officials calling Mr. Baldwin, Lloyd's supervisor, to have safety decisions overturned. Ms. Pam Perrins, secretary, continuously overhears Baldwin on telecons with ASAA, informing ASAA that they do not have to comply with safety decisions. Further, Baldwin berates the POI and other inspectors in the presence of ASAA management for the POI's safety determinations. Lloyd finally has enough of FAA management interfering with safety and regulatory issues, and sending a clear message to ASAA that the FAA management will run interference for the airline. Lloyd leave the CMS.

1993, I take over as POI of ASAA. Mr. Lloyd trains me for the position and makes me aware of the FAA/ASAA management relationship. He warns me to keep good records and notes, which I do.

I encountered the same problems as Lloyd. Baldwin continuously tells ASAA they don't have to comply with safety/regulatory issues. The ASAA VP of Flight Operations at the time was Mr. Tom Cufley. Mr. Cufley was a previous FAA inspector with oversight of ASAA and worked for Baldwin. Hence, there is a personal relationship between the two men. Baldwin is very protective of Cufley.

Early 1994, ASAA requested a life raft deviation for it's Russian operation. The FAA inspector team, including the Principal Maintenance and Principal Avionics inspector had safety concerns about granting this deviation in such a cold climate and freezing water. Baldwin told the inspectors that ASAA *WOULD* get the deviation *"or else"*. He raised his voice to the inspectors and emphasized many times that ASAA was our customer, and our job was to give them what they wanted. We disagreed, stating the flying public was our customer, and people would die unless we protected them. *This type of incident was typical of Mr. Baldwin.* In another incident, Mr. Bill Boser directed a Russian mechanic to de-ice an MD-80 with vodka and a garden sprayer. It was then done with passengers on the airplane and the APU running (a recipe for a fire). The plane then departs. I discovered the incident, attempted to go after the airline for safety violations, and experienced interference from Baldwin. Boser was a personal friend of Baldwin's. Baldwin said he thought the incident was "funny" and "showed creativity". Baldwin became angry when I pursued the issue.

August 1993, I began to suspect that ASAA management officials were falsifying pilot training records. Mr. Cufley reportedly became lost while flying in Russia. It came to my attention that Cufley had allegedly not taken the required Russia training. I directed my MD-80 APM to gather Mr. Cufley's training records. After reviewing the records, I determined that Mr. Cufley might have falsified his own training records. Because this would constitute a criminal violation, and I anticipated a possible FAA/ASAA cover-up by Baldwin, I immediately reported my suspicions to FAA Security, as per FAA Orders. Security initiated a criminal investigation. Ultimately, five management pilots lost their ATP pilot certificates. Mr. Cufley lost his VP position. *However, Mr. Baldwin and the Division Manager, Mr. Bradley Pearson, removed me from the POI position. No other*

inspector was removed. I believe I was removed because I prevented the FAA from protecting Cufley and ASAA. Ultimately, after filing a claim with the Office of Special Counsel, I was returned to the POI position. Baldwin was then removed. No action was taken against ASAA. FAA Headquarters sent a team to investigate this and other incidents in the Seattle FSDO. Their investigative results are contained in the Seattle FSDO Report.

In 1994, Mr. Phil Hoy replaced Baldwin. Hoy had worked for Baldwin previously, overseeing ASAA. He had a reputation of being a poor supervisor (reflected in the Seattle FSDO Report), and for being sympathetic to ASAA. I worked for him for about 3 years until he had me and two other inspectors removed for finding a possible *second case of falsification of records* at ASAA. This case was closed "no action" immediately after the removal of the third inspector, and after Hoy was overheard assuring ASAA officials that their problems were over.

Mr. Mike Swanigan replaced Cufley as the VP of Flight Operations. During that 3-year period, Mike Swanigan began going to Hoy with complaints about inspectors. The ASAA management was quickly learning from Hoy the he did not support the inspectors when they identified safety/regulatory problems. He constantly told the inspectors that they were "too hard on ASAA". He made a statement in a meeting with the operations inspectors that we were "finding too many violations on ASAA" and he felt "compelled to change that". (Documented in PTRS entries). Hoy began to take complaints about inspectors from Swanigan and disciplining inspectors. In one case, Swanigan forced ASAA instructor pilots to make a false complaint to Hoy and FAA Security. The pilots later retracted their statement. In the FAA Security report, the investigator stated that there was an appearance of Alaska Airlines exerting undo influence to have inspectors removed (Report involving Mr. Jewett Gibson, B-737 APM).

I identified a problem with ASAA pilots "carrying" airplanes. In other words, having mechanical failures and flying the airplane until it returned to a main maintenance base. (If you will check the records, you will determine that relatively few mechanical problems "show up" in Russia or Mexico). I worked this issue with my APMs and ALPA (Lew Richardson) to make cultural changes through positive corrective action. However, that did not work. As time went on, there were more and more instances of pilots carrying airplanes, especially in the state of Alaska. When we determined it was time to take tougher action against the pilots involved, Mr. Hoy would not allow it.

During that time, an Alaska Airlines pilot had a severe "aircraft upset" incident flying out of Juneau at night in conditions too severe to depart. The aircraft came within approx. 200' of hitting the ground. Alaska Airlines took action to hide this event from the FAA, but when the event was finally known, the Congressionally mandated Juneau Study was initiated. This study was the result of this incident and several fatal crashes in and around Juneau.

During my oversight, my APMs and I saw so many incidents and problems that pointed to an attitude by ASAA and the crews that they could do whatever was necessary,

regulations aside, as long as they got the job done. My APM saw illegal approaches being taught by management pilots in the State of Alaska, I detected the crews "busting approach minimums" by 1300' in Dutch Harbor, Alaska, I saw pilot training not being completed as approved, etc. In my professional opinion, this "get the job done attitude" developed over many years with the help of FAA management. New ASAA pilots were introduced to this company attitude during their Indoctrination training when they were shown a video about the history of ASAA, and how they found ways (explained in detail in the video, of which I have a copy) to beat the CAA (at that time). I attempted to stop ASAA from using that video in their training because it sent a negative safety message (press on, get the job done even if it is illegal, and the company will reward you). They would not cease.

Hoy had discussion with Swanigan and sought his suggestions and approval for action to "fix the inspector problems". Swanigan gave the FAA a time deadline in which to act. In 1997, I was placed in "facilitated sessions" by Mr. Hoy and Ms. Marlene Livack to learn how to be more "customer sensitive" to ASAA. During those sessions, I attempted to inform Ms. Livack of the past history and safety problems my team and I encountered with ASAA. She would not listen. Rather, she accused me of making "unsubstantiated remarks". After providing her and Hoy with proof, she claimed I failed to give her proof. She consistently emphasized that ASAA was not happy with the inspectors and we were going to learn how to be more customer sensitive. Safety did not seem to be the issue; ASAA's happiness was apparently the issue. I was shortly thereafter removed from my POI position for being too hard on ASAA. Mr. Phil Hoy and Ms. Marlene Livack (Seattle FSDO Manager) asked Mr. Brad Pearson (Division Manager) to remove me. They thought I was not "customer sensitive" enough to ASAA, because I pursued violations, documented non-compliance, and because I supported my APM and APOI who were investigating ASAA for falsification of pilot training records (certifying that FAR required line checks were given, when in fact, they were not).

FAA management first removed me, then proceeded to pressure Jewett Gibson and Les Martin to request reassignment. Pressure came by way of complaints and threats by Alaska Airlines to Livack and Hoy and subsequent disciplinary actions against the inspectors. Within about 3 months, all three of us (who were incidentally involved in the line check violation) were reassigned. Alaska was also making allegations against the remaining inspector, Steve Franklin. He was disciplined at least once or more based on complaints from ASAA.

The retaliation didn't cease upon my removal. I was subsequently admonished, given a letter of reprimand, had my civil rights violated, had at least a half dozen bids denied, and had my FAA medical certificate revoked with no justification or recourse. (Descriptions at end of chronology).

I sent safety alerts and information, as well as appeals for intervention to Mr. Brad Pearson, Division Manager; Mr. Nicholas Lacey, AFS-1; Ms. Jane Garvey, FAA Administrator; Mr. Dick Gordon, previous AFS-1, former Alaska Region Division Manager, and friend to Alaska Airlines; several of Ms. Garvey's Associate

Administrators; the FAA Hotline; Congressional Subcommittees; and Ms. Jennifer Dunn's office, U.S. House of Representatives. My safety concerns were referred back to the Northwest Mountain Region and "investigated" by Mr. Pearson, Ms. Livack, and Mr. Hoy. Of course, they found no problems. I have documents of proof, including FAA management responses disregarding my safety concerns.

Other inspectors outside the CMS also sent safety concerns to AFS-1 and others, including one who identified Alaska Airlines the "next Value Jet" just 9 months before the accident.

Much of this information is documented in an October 1998 PASS Arbitration record. The FAA has possession of this document. Key inspectors were interview during that legal proceeding and provided evidence showing interference in safety issues by Hoy, Livack, and Pearson. Management witnesses were Phil Hoy and Marlene Livack (again, who is allegedly under investigation for falsifying government documents). There are also peripheral witnesses involved over the years with ASAA who can provide similar evidence. I will provide names.

In June 1997, the Seattle FSDO received a letter from a Mr. Gustafson, a Boeing employee and ex-ASAA mechanic, describing situations where ASAA management attempted to force mechanics to falsify maintenance records. The FBI and Oakland FSDO have a copy of that letter. The Seattle FSDO should have a coy of it, unless they destroyed the letter in an attempt to protect ASAA.

Lastly, as you know, in January 1998, the press broke the story of ASAA allegedly falsifying maintenance records in Oakland maintenance base. This is the fourth time since 1993 that possible falsification of records was identified. If the 1992/93 incidents of ASAA taking credit for windshear recovery training when, in fact they knew the simulator did not have the windshear instruments, could be considered falsification of training records, then this is the fifth incident since 1992. The inspector investigating that case was harassed, and his career threatened. He most likely would provide you with additional evidence of FAA interference in correcting ASAA safety issues.

I had a conversation with an inspector in the ASAA Certificate Management Section a few days after the crash of flight 261; he stated that the FAA management and current POI (Dennis Harn) were doing some serious CYA (cover your ass) in the office. He did not say what they were doing, but I believe they are probably destroying records from the time that I was the POI. These records would prove a history of problems that FAA management ignored.

Conclusions: It appears that FAA management certainly could be negligent in allowing FAA inspectors to assure the highest levels of safety for the flying public, and in fact, could indirectly be responsible for contributing to this accident. If it is concluded that FAA management is somewhat responsible, certain individuals must be held accountable.

These individuals are Brad Pearson, Northwest Mountain Division Manager; Marlene Livack, Seattle FSDO Manager; Phil Hoy, CMS Supervisor; FAA management officials in the Western Pacific Region who were involved in harassing the investigating inspector of the falsified maintenance records; Nicholas Lacey, AFS-1; Dick Gordon, previous AFS-1; Jane Garvey, Guy Gardner, and her other Associates.

Historical Relationships:

Bill Baldwin, Phil Hoy, Bob Hill, and Brad Pearson are long time FAA Northwest Mountain Region Flight Standards management. They all have been involved with Alaska Airlines. They have all been in trouble at one time or another. The common way of solving the problem is to move people around who either get in trouble or are perceived to cause trouble. The 1995 Seattle FSDO Report, produced by AFS-30, identifies this problem and makes recommendations. However, just recently the "swap" was made again, as a result of ASAA 261.

Bill Baldwin was the POI of Alaska Airlines during the mid-80's when the carrier was small. Phil Hoy (later CMS supervisor), Tom Cufley (inspector assigned to Alaska and later VP Flight Ops at Alaska), and Ed Duchnowski (POI Alaska and later Director of Safety at Alaska) worked for him at one time or another, as did others involved in Alaska.

Baldwin appeared to have quite a close to Tom Cufley during the time Cufley was VP Flight Operations. He also appeared to be very close to Bill Boser, who was Cufley's assistant. He appeared to protect and defend both gentlemen. It was rumored that they saw each other outside of business.

Boser once showed me a photo of Bill Baldwin occupying the captain's position in a B-727 in flight. There was a flight attendant on Baldwin's lap. One can draw their own conclusions on this photograph, but to me it indicates somewhat more than a professional oversight relationship.

About 1991- POI Ed Duchnowski solicits a high paying position with ASAA, interviews, accepts, and continues to oversee ASAA until the time he leaves FAA. FAA management is well aware of this conflict of interest, yet does nothing. Inspectors, including Bob Lloyd and myself, bring this up to management yearly during ethics training. Nothing is done. Ed D. was direct FAA contact for ASAA. His relationship with FAA management contributed to the problems Lloyd and I had.

Brad Pearson is either Acting Division Manager or Division Manager from 1993-present. He kept himself intimately involved with Alaska Airlines business, and the removal of inspectors from the Alaska Airlines and Horizon certificates (ASAA sister company).

Mike Swanigan- I do not know of any historical relationships between him and the FAA. However, as the VP of Flight Operations, a great deal of his income package was tied to profit sharing and stock options. He certainly had reason to pressure the FAA management to get "fix" the inspectors. The same probably applies to John Fowler and others.

Dennis Harn, current POI, is a neighbor and very close friend of Bill Baldwin. Bill brought him into the air carrier section from general aviation, where Harn spent the bulk of his career. Dennis is very close to his sister-in-law, who is in a high management position in the Alaska Airlines financial department. She would obviously be concerned about any costs to the airline.

Chronology:

- **Alaska Airlines violations/incidents/pilot training problems in this font, as well as the incidents of putting pressure on FAA management to have inspectors removed.**

Spring of 1993, I became the Assistant POI (and acting POI, as Bob Lloyd had vacated the position in January). The inspectors involved can verify these incidents. Inspectors involved at this time were:

- Bob Lloyd- ex-POI
- Christina Dawson- PAI
- John Hubbard- PMI
- Steve Franklin- MD-80 APM
- Corky Luchs- B-737 Partial Program Manager
- Bill Whitaker- MD-80 Partial Program Manger
- Jewett Gibson- Regional Air Carrier Staff Specialist, and later B-737 APM

Many controversial issues concerning Russia operations came up. ASAA was attempting to play hardball to get what they wanted without any safety considerations or review by POI. Baldwin was highly critical of me for asking for safety documentation, as he was with Lloyd before me. He admonished me for sending letters and asking appropriate questions.
Some specific examples are:

- ASAA applied for a life raft deviation for the Sea of Okhast. Previously, Bob Lloyd (POI) and Frank Fernett (APM) had both denied the deviation based on the survivability in the cold Russian waters. John Hubbard, PMI was in agreement. When I took over, the principals were **told by an angry Baldwin (several times) that ASAA would get their deviation, "or else".**
- During meetings of the entire CMS, an **angry Baldwin told us many times that ASAA was our customer, not the passengers.** He said ASAA paid our salary, and our job was to **give them what they wanted**.
- When I questioned ASAA as to the weight bearing capacity of their alternate airports in Russia**, I was admonished and told by Baldwin that I shouldn't be asking those questions**; he said I did not need to know that information.
- I insisted that Alaska Airlines have the Russian alternate airport approach charts published in English for the pilots. **Baldwin angrily approached me and demanded to know why** I wanted that to be done. I explained that if the pilots should have to deviate for an emergency in bad weather, etc., they would need to be able to read the charts. He told me that it was possible that they would divert

in good weather. I agreed but said that we must plan on the worst-case scenario. Baldwin disagreed.

May 1993

5-6-93- I write letter to ASAA requesting more information on metric altimeter for Russia. **Baldwin admonished me for asking questions.** Later I find very similar letter from Chris Dawson. She said Baldwin approved her letter.

5-30-93- I officially got the Supervisory POI position. I had been "acting" since January. Shortly thereafter, Jewett Gibson was assigned as my B-737 APM.

Prior to Jewett Gibson's permanent assignment as B-737 Aircrew Program Manager, ASAA attempted to keep him from the certificate by making complaints. Baldwin and ASAA did not want Gibson because he previously discovered ASAA serious pilot training issues years ago when Baldwin was POI. From the time Gibson came into section, ASAA regularly made complaints and attempts to have him removed. They attempted to "wash him out" of APM pilot training. I was told by Bill Baldwin to "take care of Jewett". Alaska subsequently came after Jewett with other complaints; one from an ASAA ticket agent, and one claiming conflict of interest. Gibson was disciplined for both, although he either lacked proof, or FAA Security proved that ASAA were making false statements.

June 1993

6-2-93- ASAA de-iced with vodka in Russia under supervision Assist. VP of Flight Ops, Bill Boser. Boser friend of Baldwin. **Baldwin criticized me for following up**. FAA management saw no problem. Baldwin thought the situation was funny and Alaska was very creative. Bill Boser, Assit. VP was on the airplane and ordered the de-icing. FAA mngt. and ASAA mngt. met about this without inspectors. ALPA going to FAA headquarters with complaint about local FAA interference.

August 1993

8-24-93- I discover ASAA falsification violation. (pilot training records)

8-26-93- Steve Franklin and I gather evidence.

8-26-93- Bill Boser of ASAA faxes Baldwin a complaint that we were looking at pilot training records. **Baldwin angry with us, and admonishes us**.

8-26-93- Franklin and I interview witness at ASAA.

8-30-93- I report falsification finding to Jim Vanderpool at FAA Security, as per FAA Order 1600.38b. Security takes over investigation and coordinates with US Attorney. Ultimately, they charged 5 management pilots, including VP of Flight Operations of falsification of records, had pilot certificates revoked. *During this investigation, Jim Vanderpool discovered Ed Duchnowski had lied and said that ASAA was not keeping 2 sets of training records (real and falsified). Upon confronting the CEO at the time, ASAA disclosed that they did keep 2 sets of training records.* FAA Security inspector, Bud Gonzales informed me of this.

8-31-93- Hubbard informs me **Baldwin very upset**. Claims I was "singling out Cufley".

September 1993

September timeframe- I made trip to Attorney General's office with Security, Vanderpool and Gonzales. **They express concern that SEA FSDO mangt. will interfere** with the investigation. The Attorney General expresses the same concerns. (Zachary flies in reserves with several airmen, possible leaks)
9-8-93 meeting Zachary, Lorenz, Baldwin, Franklin, and I- FAA received complaints from ASAA - **we are told to be nicer to the airline.**
9-21-93- Baldwin angry, confronted me, about suspending checkairmen authority for airmen who falsified records. **Tells me I cannot send out letters anymore without him approving**. **Tells me I have "personal relationship problem" with the airline**. Baldwin telling other inspectors.
9-23-93- Baldwin gives me poor PER for falsification investigation.
9-30-93- Pam Perrins, secretary, witness discussion between CEO, Pat Glenn, and Baldwin. Baldwin assured CEO ASAA would get their life raft deviation **in spite of the principals concerns.**

October 1993
10-5-93- CEO writes Franklin about deteriorating relationship.
10-5-93- conversation with Art Jones, lead investigator in falsification case. Said he was **concerned about all the "leaks" to ASAA** during investigation.
10-5-93- with Lew Richardson, ALPA. Cufley says nothing will happen to him because he has friends in the FAA.
10-15-93- Conversation with Bud Gonzales about ASAA keeping 2 sets of training records.

November 1993
11-28-93- ASAA, Bill Boser, attempting to have 2 pilots lie about a conversation I had with them while enrouting. Boser makes complaint to Baldwin, who admonishes me. **The intent is to get me removed from the ASAA CMS**. I later spoke to one pilot, Mark Laura, he confirmed incident. Laura told me that he and the other pilot refused to lie about me.

December 1993
12-9-93- Vanderpool warns me **FAA mngt. very upset with me and plans to take action against me**.
12-17-93- ASAA goes to Dennis Harn, APOI, instead of me. They get answers they want. Baldwin encouraging this, and would not inform ASAA I was appropriate contact. Harn and Baldwin neighbors and friends. (Harn is being groomed for later taking over POI position, I believe)
*During the **1993/1994 time period**, I had many meetings and wrote many memos asking for upper management help in dealing with an **abusive supervisor**. I was largely given lip service and ignored. Towards my removal time, **upper management became aggressive in their treatment; even to the point of telling me I needed "medical evaluations"**. Management was also very tough on my APM's, whom I defended vigorously for doing their jobs well. I was their supervisor for part of this time period.*

January 1994

aggressive in their treatment; even to the point of telling me I needed "medical evaluations". *Management was also very tough on my APM's, whom I defended vigorously for doing their jobs well. I was their supervisor for part of this time period.*

January 1994
1-24-94- meeting with George Bagley, then VP of Flight Ops. about problems, violations, attitude, relationship.

March 1994
3-22-94 -I am notified that I am being transferred to the region. Order was given by ANM-200 (Pearson)
3-23-94- I file complaint with the OSC.
3-28-94- Zachary threatens to send me for "medical evaluation".
3-29-94- message from me to Zachary asking for reasons for reassignment in writing. Never received any.
3-29-94- meeting with Roger Knight, Brad Pearson, Steve Franklin, myself and other regional personnel. I was told it **was "in my best interest" to drop this**. (implied threat)
3-31-94- Lew Richardson, informs me Zip Trower, Steve Sanford, Steve Day, and Bill Boser convinced CEO that I was cause of all their problems, hence my removal after placing pressure on FAA officials.

Note: the region had historically been known as the "dumping ground for problem employees". Presently, there are 5 employees who have been removed from other sections. It is very difficult to ever leave the region once you get there. Dead end.

April 1994
4-3-94- I am reassigned to the Regional Office to do "staff" work.

May 1994
5-13-94- David Harrington, AFS-200 admitted to Lew that **my move was politically motivated**.
5-23 to 6-2-94- Accardi sends 3-person team to conduct interviews with SEA FSDO employees after my official complaints. I was returned to POI position after team left in June. Baldwin removed from ASAA CMS during my reassignment at the region. Phil Hoy was moved from the general aviation section to the ASAA CMS. Hoy was removed from the general aviation section because he was such a poor supervisor that several of his employees were fired falsification of airmen certificates: issues he should have been aware of (see SEA FSDO report). Keeton Zachary, SEA FSDO Manager, also removed and sent to the region. Sam Aaron is transferred from Region to SEA FSDO manager positon.

Seattle FSDO report is eventually released. It criticizes the Northwest Mountain Region for simply "swapping" supervisors when they get into trouble instead of addressing the problem.

June 1994

6-12-94- official reassignment from regional office to ASAA section. Hoy is my new supervisor.

September 1994
9-27-94-I file violation on ASAA for allowing an unauthorized person on the cockpit jumpseat on a revenue flight. ASAA's Mike Swanigan very unhappy with me.

October 1994
10-12-94- During the CMS meeting, I relayed my conversation with Sam Aaron, SEA FSDO Manager. Sam told me I would do violations where we see them (Sam was generally supportive, but left the office in a short time. After his transfer, I again experienced an increase in supervisory interference). I also relayed the fact that we had to may "leaks" to ASAA.

1994-1995 time frame, Roy Peterson was **removed from his job and fired from the FAA by Brad Pearson for finding violations on ASAA sister airline, Horizon Air.**

Sometime in 1995, we participated in a congressionally mandated Juneau Safety Study. Team leader was Mr. Pete McHugh out of ASY. The study lasted about 2 years, and resulted in many safety improvements at the Juneau Airport. Alaska Airlines was very resistant to any changes. They took a hard line against the FAA, to the point **of making false complaints about the inspectors to FAA Headquarters and the local Juneau newspaper.**

February 1995
2-9-95- My letter of investigation about unqualified airmen in revenue service. ASAA failed to provide downgrade training.

March 1995
3-2-95- Phil conducts **Weingarten meeting** with me, no advance notice.
3-30-95- Tom Britz conducted official pilot training for ASAA although he was unqualified. His ATP had been revoked for falsification of records, but ASAA was allowing him to instruct pilots and record training.

April 1995
4-5-95 - ASAA failed to provide training records of contract ARCO pilots. My letter said they must submit records and give full course of instruction.

May 1995
5-10-95- Meeting held between Sam Aaron, Bill Baldwin, and myself. **Bill was attempting to have me disciplined by Sam.**

June 1995

6-13-95 - SEA FSDO report. **Hoy was very upset, and became emotional** over this report at several subsequent meetings.
6-20-95- SEA FSDO report. cc:Mail from me to Sam Aaron about **rumors that certain management officials plan to "tear me to shreds"** over the SEA FSDO report. (this will keep coming up over and over, even after my 2nd removal in 1997). I faced continuing reprisal for this in the form of hostile confrontations

July 1995
7-12-95- I discover minimums "busting" at Dutch Harbor, Alaska. Being promoted by Terry Smith, ANC base manager.
I heard rumors that this was occurring, so I went to Dutch Harbor to check it out. The Captain was Kevin Earp (one of the previous falsifiers). He was concerned and admitted to me that Terry Smith was forcing the ANC pilots to bust minimums (1900 feet) by 1300'. He would have busted minimums, but I was on the jumpseat, so we diverted to Cold Bay and took 3-hour delay. Mike Swanigan go on the phone and told me I was out of line and Alaska Airlines had special permission by someone in the FAA to fly contrary to the approach minimums. I asked him to fax me the documentation, but he could not produce any. When I returned to Seattle the next day, **I was admonished by Hoy** for causing Alaska Airlines problems. I gathered all the operations inspectors for a meeting and drew out the scenario I experienced and reviewed the approach chart. **Hoy and Harn both said that it was OK for Alaska to bust minimums by 1300' because they had been doing it, and they hadn't hit anything yet!** Hoy made it clear that he disagreed with me. I explained that there were legal processes to go through to change minimums and they could not arbitrarily change minimums. They disagreed; however, Alaska Airlines later went through the legal process and had the mins. changed.
7-28-95- Letter from Dave Harrington, AFS-200, informing ASAA that Headquarters supports my Dutch Harbor "catch" and national policy will be changed as a result of my work.

August 1995
8-15&16-95- ASAA Tom Britz conducts sim. training with revoked pilot certificate.
8-7-95- ASAA again complains about strict oversight.
8-29-95- I found justification for *Inspector of the Year Award* for Dennis Harn written by Hoy. **Hoy gave him credit for my work.**

October 1995
10-5-95- ASAA CEO sends letter to Steve Franklin about the deterioration of the relationship between FAA and ASAA. During falsification of records. Steve was inspector who researched the records for me and was under extreme criticism by ASAA.

November 1995
11-1-95-My letter to Mike Lawrence addressing training changes. I cite that ASAA has not complied with the settlement agreement on the Britz case. The agreement is they would rewrite the Approved Training Manual. (As of 3/98, they still had not done this.)
11-4-95- My letter to ASAA citing ATC complaints about ASAA filing a flight plan to Burbank instead of Los Angeles Int'l as a way of avoiding gate hold in Seattle. Once in

the air, they change their flight plan. This overburdens ATC and becomes a safety issue. (ATC is still making complaints to this day)

January 1996

January 1996, ASAA was classified as a "major" airline. This gives us even more visibility as regulators. Now 10th largest pax. carrier.
August 1996, ASAA rated #1 in safety record. Had excellent in-depth inspection (NASIP) in flight operations. I believe due to our strict and constant oversight. **By 1997 their attitude was increasingly non-compliant and they slipped to #2. DOD placed them on "close watch" list.**
1-9-96 -I discover ASAA not using overlays for JNU training as per Juneau Study requirement.
1-10-96 - My letter to ASAA with notification that FAA was revoking authority to use certain departures from Juneau for safety reasons. A simulator demonstration showed that the departures might result in impact with terrain in most cases of engine failure.
1-12-96 - My letter-ASAA failing to conduct Juneau training as per training program and operation specification by failing to use overlay. All pilots must be retrained. Alaska retrains the pilots.
1-18-96- my letter to ASAA citing their failure to retrain pilots as agreed upon for Juneau overlays.

February 1996

2-6-96- ASAA report re: unqualified check airmen on IOE- 4 revenue flights.
2-14-96- Jewett has flight with Terry Smith where T.S. violated instrument approach procedures and sterile cockpit regulations. Terry was instructing a student at the time. Terry states "things are different in Alaska". (talk to Gibson).

March 1996

3-11-96- My letter to ASAA closing the overlay case. All pilots retrained. No other action.
3-29-96 -My letter- ASAA failing to provide proper notification of RNP events. Also address first cadre instructor re: lack of notice.

April 1996

4-9-96 - My letter to ASAA citing that it is unapproved to use the same Checkairmen for 3 days of training and checking under SVT program.
4-11-96 - My letter- ASAA failing to conduct evaluations of procedural trainers as per AC-120-45A.
4-18-96 - Swanigan call Jewett a yellow back stabber for grounding pilots without proper line checks and threatens to have him removed.
4-29-96- record of meeting with Aaron, re: inspector time, assistance.

May 1996

I continually requested more inspector assistance to increase surveillance on ASAA, as their compliance attitude was becoming worse. I justified this for Hoy many times.

However, Hoy increasingly began to restrict us from conducting surveillance. After Dutch Harbor, he informed inspectors that work in other areas like Alaska were a geographic responsibility- we were not to do surveillance.
5-3-96- message to Hoy asking for inspector assistance.
5-13-96-- message from me to McHugh expressing concern for lack of inspectors, asking for surveillance.
5-13-96- me to Hoy asking for more inspectors.
5-15-97- our office received copy of regulation change, which directs the FAA to stop "promoting" carriers and concentrate on regulating. I show to Hoy.

June 1996
6-5-96- I wrote justification for check airmen withdrawals.
6-10-96- Aviation Daily article, Value Jet, and the seriousness of falsification of records- most egregious, should shut airline down.
6-26-96- Fernald writes Gibson about lack of assistance (shortage of inspectors), states ASAA has asked FAA for more help.

July 1996
7-9-96 - My letter to ASAA stating they were in non-compliance of their approved training program and Exemption 4416E (aircraft pictorials)
7-11-96- ASAA writes me letter stating false information about Gibson during a check ride. ASAA Airmen Vincent verified info was false.
7-18-96- Sam Aaron writes Mike Swanigan (ASAA) a letter informing him that the FAA will not remove Jewett because of a customer service agent complaint.
Alaska Airlines agent, Lori Anderson, made complaints against Jewett Gibson. Gibson was attempting to ride jumpseat, and was being hindered by Ms. Anderson. Ms. Anderson made allegations, which she could not prove. She stated that she had witness' including ASAA Director of Security. However, during interviews, no witness' were produced. In spite of the appearance of false statements by Anderson, Jewett was disciplined by Hoy. I wrote a hotline complaint because I believed this type of thing was diluting the inspector effectiveness and would result in a degradation of safety.
7-19-96- Withdrawal of Juneau procedures. Time given before action.
7-19-96- Fernald gets verbally abuse to Gibson. Makes statement to me, he didn't care how is message came across; it was end result he wanted.
7-30-96- my letter to ASAA about MD-80 aircraft pictorials and their failure to training according to their training program.
7-30-96 - Pete McHugh, FAA headquarters, Juneau Study team lead, sends message to ASAA that POI (me) is a dedicated professional with safety as no. 1 priority.
Summer 1996 ASAA Newsletter- B-737-400. States that crews are not familiar with certain procedures at certain airports. This is a training problem.

August 1996
8-7-96- message from me to Gibson, requesting extra inspectors.
8-7-96- Aaron to Hoy and me. He is concerned about lack of inspectors. All ASAA designees expired.

8-15-96- Sam Aaron writes letter in response to FAA Hotline, written by me, about inspectors being intimidated from filing enforcement's, as a result of ASAA complaints against inspectors.
8-16-96- - from ASAA requesting more inspector support/ list of projects.
8-21-96- me to Hoy/Aaron pleading for more inspectors.
8-23-96-me to Hoy asking for more inspectors, ASAA requests for help.
8-23-96- me to Hoy about extra workload of non-essential items, state we may have to start delaying ASAA's projects.
8-29-96- me to Hoy about inspector time, assistance.
8-29-96- me to Hoy re: ASAA's problems with lack of inspectors.

September 1996
9-3-96-I withdraw Life Raft Deviation ops specs as per AFS-200. ASAA didn't like, but decided not to fight. This deviation never should have been given to Alaska but Bill Baldwin told the PMI and I that we must give the deviation "or else". (implied threat).
9-5-96-letter to withdraw ASAA's use of STI simulator for certain types of pilot training due to deficiencies in simulator, as per ASAA themselves.
9-5-96- My letter of investigation to ASAA for interfering with inspectors (Jewett Gibson) access to the cockpit, as per regulations.
9-10-96- me to Aaron requesting more inspectors, Hoy afraid of other supervisor's complaints that the ASAA section getting more help. Hoy bending under the political pressure and not supporting our requests for more inspectors.
9-11-96 My letter to ASAA citing a violation for installing GPS on B-737-200 but failing to train pilots as agreed upon.
9-16-96- CMS surveillance for year is 2.9%, for quarter is 6.3%. Trend I have been telling Hoy about and requesting assistance.
9-30-96 - My letter to ASAA proposing withdrawing Doug Whato's Checkairmen authority. (see Juneau file- Whato had been making false statements about POI and FAA to our FAA Headquarters, attempting to create conflict between ASAA and FAA. I determine he is not a good representative of FAA)

October 1996
10-23-96 - I discover ASAA Terry Smith flying "direct" out of Dutch Harbor contrary to Ops Specs and regulations. I file violation against ANC base manager and check airmen.
10-25-96 - My letter to Mike Swanigan informing him that I could not lower weather minimums for RNP approaches because they were not doing items as agreed upon. Justification and safety must be proven first.
10-26-96 - I find derogatory article about the FAA posted in the women's restroom at ASAA. It was not in the men's room.

November 1996
11-5-96- Dullaghan sends me copy of memo about ASAA's attitude during check rides in 1998 where they attempted to get inspector fired.
11-7-96- Franklin passes accolades to Hoy about serious training deficiency discovered by me.

11-20-96 - My letter to Mike Swanigan about Terry Smith's newsletter to the Anchorage pilots encouraging unsafe practices.
11-22-96 - my letter to ASAA about Marty Valla and need for recheck of his ability to hold a pilot certificate. He nearly lost control of aircraft while on instrument approach with inspector on jumpseat.
11-29-96 - My letter to Mike Swanigan about ASAA failing to train for circling approaches and conducting illegal circling approaches in the MD-80. It also cited a violation of the approved training program by using simulator scenes that were not approved.

December 1996
12-3-96 - letter to Mike Swanigan about MD-80 circling deficiencies.
12-1--96 - Letter to ASAA about their failure to have training pictorials for MD-80.
12-4-96 - My letter to ASAA pilot about requirement to re-examine his pilot abilities as a result of a near disastrous approach with an inspector on the jumpseat.
12-10-96 - Letter of Investigations sent to Smith and Gray for flying "direct".
-96- I file Hotline complaint about ASAA's attempts to have inspectors removed.

January 1997
1-3-97- conv. with Lew Richardson, ALPA concerning ASAA violating 10-knot wind restriction in Juneau. Places them too close to terrain. I addressed with Majer later.
1-10-97 - I receive package of information and memos concerning Reno airport and the new training requirements from POI, Reid Walburg. Reno Air was lead airline.
1-13-97- hotline about ASAA influencing the FAA Alaska Region re: Terry Smith. Dick Gordon was Division Manager, now AFS-2 during my removal. Connection?
1-24-97- Phil has restricted me from contacting region and headquarters' personnel to ask for guidance, as per my job description. I have been "reprimanded" several times for the way I used internal E- mail, but not guidance was ever given. *I also address **Phil's many absences** from the section and ask he be more available or leave contact #.* I make 5 requests.
1-28-97- My letter to Mike Swanigan about the use of two Checkairmen who were under investigation (Terry Smith and Rex Gray- going "direct" violation).
1-28-97 - Letter to ASAA for using the same check airmen for training and checking.
1-29-97- Pete McHugh warning me that **FAA officials were after me and planning to take action.**

February 1997
2-2-97 - My letter reinstating Doug Whato's Checkairmen authority.
2-4-97 - My Letter of Investigation to CEO John Kelly for a collision between an airplane and a fuel truck.
2-4-97- Hoy doubts my reporting of a conversation between Swanigan & me.
2-24-97 -My letter proposing to withdraw Terry Smith's Checkairmen authority. Letter of warning issued by me to him for "direct" violation.
2-25-97- letter of investigation sent to ASAA for boarding intox. pax. Franklin's investigative package discussed recent compliance attitude. FAA **Mgt. "lost" documentation**, told Franklin he had no case.

2-27-97- conversation with Lew Richardson. He tells me Terry Smith starting petition to have me removed. Conversation with Swanigan where he appears to lie about knowledge of this.
2-27-97- I inform Hoy of Terry Smith's petition to have me removed, as per ALPA.

March 1997
3-6-97 -My letter to Paul Majer addressing requirement to use approved checklists in their aircraft. Checklist change required as a result of 2-737 accidents, must have FAA approve first to assure checklist meets requirements of A.D. ASAA failed to seek approval.
3-11-97- Hoy's message about meeting with CEO about large maintenance fine. This is one of the issues ASAA brings up later to throw us into facilitation. John Fowler, Mike Swanigan, and John Kelly of ASAA were involved in meetings with the FAA (Livack and Hoy) to discuss what should be done about the inspectors.
3-12-97- my Geographic request for extra surveillance for B-737 checklists.
3-14-97- article released about $810,000 fine against ASAA. ASAA very mad about this and line check violation discovery. These are what prompt ASAA to start threatening to pull out of AQP.
3-20-97- ASAA informs us they will no longer supply us with information, as a result of Hoy's meeting with CEO about large maint. fine.
3-24-97 - My letter to ASAA about using unapproved training.
About 3-31-97- Livack become SEA FSDO manager.

April 1997
April through June, I filed many PTRS entries under 1010 and 1045 to document the abusive situation in the SEA FSDO. They are under that section.
April 1997- Dan Beaudette officially goes to CSET, Pearson takes over ANM-200 permanently.
4-2-97- I request lunch meeting with Livack to discuss ASAA.
4-3-97 – Draft Letter of Investigation written to ASAA about line check violation. Appears to be falsification of records again. Gibson found and reported to me.
4-7-97- I send Security first message about line check falsification. I use "hypothetical" situation because last time (1993), I was removed.
4-7-97- me to Hoy about my desires to work as team, **leaving principal's out of "loop".**
4-8-97- I have meeting with Livack to discuss ASAA, bring her up to speed.
4-8-97- meeting Hoy, Swanigan (ASAA), and I. Swanigan out for Jewett's firing. Said he was going after Jewett for conflict of interest between Jewett and some Checkairmen. (later, Checkairmen who were forced to lie, retracted their statements).
4-8-97 - Letter of investigation to ASAA for using unapproved checklist in B-737.
4-8-97- Phil writes apologetic letter to ASAA for the inspectors finding a line check violation.
4-8-97 - Hoy and I have meeting with Swanigan. Swanigan states he wants Gibson removed. Hoy later tells Gibson that Swanigan is "gunning for him" and Hoy doesn't know why.
4-9-97- Martin, Gibson, I attend very hostile check airmen meeting. ASAA management appears to be encouraging the hostility at meeting. Personal safety fears.

4-9-97- I inform Hoy about hostile meeting. **Phil asks what *we did* to "encourage" behavior**.
4-14-97 - Hoy had meeting with Gibson, Martin, Franklin, and I. **Tells us we are too hard on ASAA and he felt compelled to change that.** Cc: from Hoy- appears surprised about "falsification of records".
4-14-97 - I ask Hoy for guidance on how to work with ASAA on enforcement issues in light of their effort to remove inspectors.
4-13-97- Meet Tom Cufley, former ASAA VP, in PDX. He tells he saw the petition initiated by ASAA check airmen to remove me. Check airmen are management.
4-14-97- I report petition to Hoy again. Hoy shows no support.
4-14-97- my message to headquarters about ASAA attitude and violations. **Livack and Hoy took exception.**
4-14/15-97- Terry Clark, Safety Manger ASAA, visits me about ASAP Program. He stated that all of ASAA's internal problems are causing problems for the FAA inspectors when they point them out. He said ASAP would help that. ASAA still willing to discuss Partnership.
4-15-97- Swanigan, Hoy, Livack have meeting. Swanigan tells FAA to "fix" inspector problems" or ASAA will pull out of AQP (a voluntary program). Then Swanigan sets a date for the FAA to respond with a plan. (Hoy and Livack appear to think this is appropriate)
4-15-97- I have meeting with Hoy and Livack to "discuss how we are to 'handle' violations". I **sense they want me to drop line check violation**. Hoy concerned about sanction. I said we couldn't ignore violations.
4-16-97- I write Livack cc: Mail with an overview of the safety problems and violation history that we have worked on ASAA. This information was to give her an overview and an understanding as a new manager of the issues we faced every day.
4-16-97- ASAA makes false complaint to Livack about HUD delay. **Livack upset with me.**
4-17-97- Gibson to Hoy re: why he disagrees with line check letter. **Hoy mad.**
4-18-97- Swanigan threatens Gibson with his removal. Gibson writes memo asking for mngt. help. No response. I later send memo addressing issue to Hoy and ask for Legal and Regional input. Hoy says he perceives no threat. I forward concerns to Legal myself.
4-18-97- me to Hoy about me doing his job (*he is never around- this was a problem that I brought up often. He didn't know what was going on, and he became upset when ASAA complained*).
4-18-97- me to Livack re: Hoy not doing his job, me having responsibility but no authority.
4-21-97- Livack, Hoy and meeting with CEO, John Kelly and Mike Swanigan. They don't like direction *national FAA* going. **Threaten to pull out of AQP. "FAA must fix inspector problems".**
4-21-97- I respond to Hoy about Gibson's message about threats.
4-21-97- Captain Sullens message about violation. He's angry that we are taking action. (for flying an airplane with a known mechanical problem). ANC based pilots angry. ANC pilots influencing ASAA to remove me.
4-23-97- Gibson asks for transfer to the Region **due to mgt. harassment** and no support.

4-23-97- ASAA attempts to issue illegal guidance about checkairmen.
4-24-97- Meeting between Principals and Hoy/Livack, then Ops inspectors and Hoy/Livack to **announce that we had a "relationship" problem and we were going to work it out.** Livack asked for feedback and mission statement, supplied 4-28-97. Places us in facilitation. Principals all expressed **concerns of message being sent** to ASAA.
4-24-97- DOD places ASAA on "close watch list". DOT Donahue riding ASAA jumpseat in Alaska. He hears complaints from pilots about Sullen's violation. Livack concerned about Donahue's comments- she doesn't want to be sent to JNU as manager.
4-24-97- I ask Hoy for guidance on how we should handle our projects with ASAA.
4-25-97 - Letter to Dean Schwab about line check training issues.
4-25-97 - Letter to Mike Swanigan addressing interfering with inspector's access to cockpit (again).
4-25-97- I send letter to Swanigan about hostility at check airmen meeting. Hoy doesn't like it.
4-28-97- Hoy has early meeting at ASAA, then spends entire day in FAA Personnel office. Why? (To have me removed, I believe)
4-28-97- Memo from me to Livack with suggestions to identify to "problems". I address 12 issues that I believe are the root causes of the problems. No one else complies with request for feedback. (also see 6-6 cc: Mail). *This is start of my "Livack" problems.*
4-29-97- I inform Hoy of rumor that ASAA is threatening to move certificate. **Hoy is clearly concerned.**
4-29-97 - Ed Duchnowski informs me ASAA will no longer share information with us because things show up on web site (we have no control of web site).
4-29-97- facilitated meeting. Inspectors ask for outside investigation. Livack asked for specific complaints, but refused to provide.
4-29-97- Hoy discusses Jewett/agent problem with me. Hoy tells me ASAA was in violation by denying Jewett boarding and tells me to write a letter. **He later tells me to drop it, and even has John Callahan (attorney) tell me to drop it.**
4-30-97- my first letter to ASAA proposing to revoke computer record keeping authorization because of apparent falsification of records via electronic records.
4-30-97- Memo from me to Brad Pearson addressing Jewett's request for lateral transfer to the region, and the reasons I believe this would be a mistake (allow ASAA to believe they can get rid of inspectors by complaining).
4-30-97- Hoy has telecon with Joyce Fischlin and Keeton Zachary and tells them of Swanigan's threats to Gibson. On 4-18-97, he told Gibson he saw no threat. (was this so he could punish Gibson to get a track record started for his removal?)
4-30-97- Memo from me to Livack asking that Mike Swanigan's threats to Jewett be addressed.
4-30-97- I write memo about negotiating about replacement B-737 APM for the good of the section. On 5/13 **Livack told Hoy that I have no say, and not to talk to people in the region.**
4-30-97- regional notification of DOD close watch list.

May 1997
April-December- management has many meeting with Legal to discuss line check violation, inspectors not included. This is very unusual.

April-June time frame, I filed several grievances (4-6) to document information, as per Jim Kelly, Pass VP. I did this as a means to document perceived FAA management interference into inspectors pursuing violations.
Sometime after the line check violation, ASAA Winkleman brags to several inspectors that ASAA could easily hide evidence in their recordkeeping system if they wanted to. I made decision to made ASAA keep paper records for a 90 day period so we could validate accuracy. **FAA management never allow it to happen**.
5-1&6-97- Inspectors ask Hoy not to inform ASAA of LOFT investigation until we had time to investigate. Jewett Gibson discovered Alaska Airlines not training LOFT according to approved program. Further, Alaska was cutting LOFT training short by ½.
5-1-97- CMS meeting with ASAA. Hoy not present. I ask Mike Swanigan for specific complaints about inspectors. Swanigan says he has problems with certain "inspectors". He also said that Livack and Hoy sought his opinion as to what should be done about the inspectors, and got approval from Swanigan to use facilitated meetings to correct the problem!
5-1-97- my letter to CEO Kelly about relationship as related to safety.
5-1-97- ***Hoy calls Swanigan and informs him of our LOFT investigation and violation***, and status of inspector facilitation. I overhear, and then confront Hoy. Previously, inspector's asked Hoy not to inform ASAA early. Illegal as per FAA Order 2150.
5-1-97-Hoy admits to ops inspectors that Swanigan never gave him specific complaints against inspectors.
5-1-97- Hoy tells inspectors they are conducting "clandestine investigations" for looking into training issues. **He orders us not to conduct any more.**
5-1-97- I informed Swanigan at a meeting of the upcoming letter changing his computer record keeping ops specs, he replied "its pay back time".
5-2-97- letter from me to Swanigan- re: tardy response to self-disclosure of last August. Ignoring March 31, 1997, 10-day response deadline. I asked several times before for info.
5-2 & 8-97- conversation with National Resource, Owen Dullaghan, about line check. He stated we had a qualification problem and it was serious. Falsification also. We must stop it. ASAA can lose operating certificate.
5-6-97- facilitated meeting. **Appearance management does not want ASAA violated**. Livack again mentions that we are doing things well and getting good feedback from headquarters.
5-6-97- Swanigan tells Hoy he will supply specific complaints about the inspectors. He never does.
5-6-97- me to Hoy indicating that ASAA is blaming us for pulling out of AQP. Les Martin called me from STL about it- **Hoy wants to talk, is upset.**
5-6-97-conversation with Bob Lloyd, previous POI. He left the ASAA section because of lack of management support.
5-6-97- Livack gets involved with drunken pax. violation of Franklin's. **Evidence turns up missing from the package**. It is very unusual for a manager to take such a personal interest in violations.
5-6-97- my letter to AQP branch manager asking to not allow ASAA into full AQP until falsification of records investigation is done.

5-6-97-Hoy to Gibson stating that he **wants to tell ASAA the details of the investigation** over Gibson's objections.
5-7-97 - I supply Inspector Handbook pages to Hoy, concerning recently identified (by me) safety issues.
5-7-97- Meeting called by Hoy between inspectors and ASAA to **allow ASAA to investigate their own violation.** Hoy gave Swanigan the details. Gave them 10 days to do it. Later, Bob Lloyd said, "you never tell the company the details of an ongoing investigation!"
5-10-97 - Letter received from ASAA. Mike Swanigan address' excuses for the line check and LOFT violations. His excuses are erroneous, as they are not part of the approval. The dates ASAA wrote on both pieces of correspondence don't make sense. No wonder they can't keep their records straight.
5-12-97- to Hoy and Livack re: the meeting they requested with me about ASAA safety issues and compliance history. I ask what documents I should bring. Left voice mails. No answers. Hoy tells me I have a meeting with Livack the next day about "safety issues**". I felt a trap**. I feel it will be about safety memos I have been sending.
5-12-97- Livack has meeting with PASS rep. Steve Franklin and Whitaker. She said **she didn't like the memos** I was sending, and I would never make it into management, even though I have potential. Bill told her it appeared to him the **facilitated meetings were meant to "fillet" me**.
5-12-97- Conversation with Ross Roseman, ALPA. Livack accuses me of talking to ALPA about violations. Ross stated I never did. Ross had conversation with Swanigan. Told Swanigan ASAA needed to clean up their own house. Swanigan angry. (perceives ALPA/FAA relationship as a threat. (ALPA involved from Partnership aspect).
5-12-97- me to Hoy about the problem of ASAA's unresponsiveness to our requests for statements, and message it will send if we don't pursue.
5-12-97- Livack asks for information which I supplied via cc:Mail same day. Mssg. **tone very nasty.**
5-12-97- my message to Legal re: Jewett's threats and **mangt. unresponsiveness to my request for support**. Tell them ASAA attempting to get rid of us.
5-12-97- mgts. interference with Steve Franklin's violation against unruly pax.
5-13-97- facilitated meeting. **Very hostile.** Bill Whitaker in attendance. **Hoy and Livack very upset about our ASAA violations. Said when there were only 3 inspectors overseeing ASAA, they didn't have all these problems.**
5-13-97- A second meeting between me, Hoy, Livack, Whitaker. **Meetings were confrontational and hostile** because of me "mission..." feedback memo. Livack says I was a problem to other managers. Phil told me 2nd meeting was about ASAA. Not true. **Livack tells me I am going to understand "my place in the FSDO.** Livack apparently attempting to trap me into saying I am not doing my job. **Threatening statements and questions**. Whitaker statement. Union rep. also said in private meeting with Livack, she said I was blowing my chances of ever being a manager. Pearson sent me cc:mail saying that I discuss with FSDO mgt.
5-13-97- at a later meeting that day with Hoy, he told me he hates coming to work anymore. I stated I felt **Marlene was attempting to fire me**.
5-13-97 ALPA praises my safety initiative in a meeting with Hoy and Livack. It is not passed onto me by mgt.

5-13-97- my letter to Paul Majer citing training issues at Reno. I state that training must be done.
5-14-97- Jim Winkleman, Manager of Safety at ASAA, makes comment that Hoy is an "empty suit". (Obvious no respect)
5-14-97- me to Hoy requesting guidance on acceptable use of cc:Mail. He tells me my contacts with anyone outside office is not allowed.
5-15-97- inform Hoy of ASAA's refusal to train on Reno or provide information.
5-15-97- Meeting with OIG, Tristin Linkert. Gibson, Franklin, Martin, and me. Memo to Tristin Linkert about ASAA violations, **mngt saying it is only "paperwork violation"**. Follow up with faxed memo. About violations.
5-16-97- Livack writes me a memo addressing my 4-16 and 4-30 memos to her. She asks me to supply her more information on ASAA compliance history. Asks for a memo from me by COB on May 23, 1997. **It is obvious she is not happy** with my comments about management in my past memos, and orders me to tell her if any management official is interfering with conducting investigations, etc. I do.
5-16-97- facilitated mtg. No ground rules established. **Not a "safe" environment, according to facilitator**. Three principals agree that the meetings are a waste of time, and meant to appease ASAA.
5-**16-97** - Bill Blake of regional office briefs Hoy and Livack about SEA office eval. Tells them I should be commended for my work.
5-19-97-- Dullaghan discussion: said Phil is the problem. Livack team leader on AEG investigation where Dullaghan lost his job. Livack said "customer service" 118 times in her report. **Rarely mentioned "safety".**
5-19-97 - I reply to Livack 5-16 memo re: performance, ASAA issues, CMS issue. *(Good memo)* Asking for clarification on certain issues, including 5/13 meeting.
5-19-97- me message to PASS asking for intervention, **risk of removal**.
5-19-97- me to Hoy asking if he ever got any feedback from ASAA on LOFT violation. He asked them to investigate their own violation.
5-20-97- Facilitated meeting. Hubbard points out that **management shouldn't be making principal's decisions.** All principals expressed desire to quit meetings.
5-20-97- I ask Les Martin to get out the Letter of Investigation on the line checks**. He said he was afraid of Hoy and Livack.**
5-21-97- meeting with Livack, Hoy, Swanigan and me re: relationship between ASAA and FAA.
5-22-97 -Les Martin's letter of investigation to John Kelly for the line check violation.
5-22-97- documenting meeting between Livack and inspectors. Threats from ASAA. Complaints from ASAA about proposed recordkeeping requirement, but no other specifics given to inspectors. **Hoy tells me he disagrees with change and trusts Swanigan**. **ASAA complained that they were being held to higher standards, Hoy agreed.** *(I guess I was doing my job too well)*
5-22-97- memo to Linkert about 3 ASAA violations. Provide evidence and copies of cases.
5-23-97- Bill Whitaker message about 5-22 meeting. **Perception: to get rid of M.R.**
5-23-97- I tell Hoy how I perceive the meetings as a way for Livack **to get rid of me. He agreed** that the **meeting in her office was hostile** and did not go as he would have liked. He asked me to trust her. Steeb witnessed. ASAA unhappy- not getting work done.

5-23-97- facilitation. Livack admits she doesn't understand the "principal system". She got very nasty with me. Livack said Swanigan complained that I was too busy in facilitated meetings and doing internal things to help ASAA. Hubbard tells Hoy and Livack to get focus off MR and onto the subject. He got argumentative to divert attent.
5-27-97- Pearson to Franklin, "the relationship is going to change, I don't care who changes, but it is going to change".

During this timeframe, Les Martin was involved in a violation against an ASAA B-737 pilot, Rick Zimmer, for not properly complying with an MEL, not conducting a proper preflight, and failing to write up the airplane upon landing before turning the airplane over to maintenance for repairs. Les sanctioned the pilot to a 15-day suspension. **Phil Hoy told Les that the sanction was too severe** (although we were addressing a trend of "carrying airplanes" at the time). **Hoy would not allow Les to process the violation, and the matter was dropped.** Hoy indicated that ASAA, and Swanigan in particular was unhappy.

June 1997

June- as per Chris Dawson, all facilitation meetings are canceled for June and July. (None after my removal, although Livack claimed they were critical)
6-2-97- Steeb about ASAA class where they promote false story about drunk FAA inspector. She confronts issue and gets it stopped.
6-2-97-I receive memo and voice mail from Hoy informing me that I am not to have any contact with CEO ASAA. **Says I cannot have any contact with anyone outside of CMS** without permission. Says I am the problem.
6-2-97- Memo from me to Hoy asking for clarification and guidance on Hoy's voice mail message that I was not to have any contact with CEO of ASAA. I requested formal description and PD change indicating of exactly how I was expected to conduct business. (Memo had wrong date on it, of 6-5. Date was actually 6-2)
6-4-97- to me from Pete McHugh of headquarters sending his *admiration for taking tough stance on safety issues in Juneau.*
6-4-97 -Complaint from ASAA about my CEO letter. Phil tells me to find every letter I ever wrote to Kelly. Hoy tells me **Livack is angry. Interf. with safety duties.**
6-4-97- Memo from Livack to me about a **conversation she had with Brad Pearson about me**. Erroneous information. She asks for copies of PTRS records and records of violations, etc. **Memos getting more hostile.** She accuses me of creating a hostile work environment for my supervisor because of the memo feedback I supplied at her request, concerning the issues as I saw them (including supervisors part in the situation).She objects to cc's to other inspectors involved in facilitation. She reiterates that I am supposed to continue working in accordance with my PD, and orders me again to report any supervisor who is interfering with my job. **Contradiction.**
6-4-97- message from me to inspectors/PASS about **missing evidence**, ASAA history, facilitation.
6-4-97- me to Hoy asking again for guidance on how to handle business. No answer.
6-5-97- message from Owen Dullaghan informing me that I am required as a federal employee to report fraud, waste and abuse. (in reference to missing evidence).

6-5-97- I write Hoy and ask for help in gathering the information Livack wants. I address safety issues caused by the extra demands of Livack.
6-5/9-97- I write justification for Hoy about revocation of computer recordkeeping, including Lloyd's letter to ASAA of 7-20-92 and referenced memo. Also forwarded violation info for Livack.
6-5-97- Hoy to me telling me to proceed on LOFT violation as I deem appropriates. *(Shortly later he and Livack accuse me of performance problems, yet he trusts my judgement here?)* FAA **management had this case dropped after my removal**.
6-6-97- FAA headquarters tells me to revoke Reno low approach until they train. I tell APM's. This issue going on for months. I sent cc to O. Dullaghan (AFS-200) asking how to proceed.
6-6-97- Memo from me to Livack replying to her 6-4 memo about **her conversation with Brad** Pearson. I clarify issues and point out a recent situation where an enforcement file came back from Hoy with **critical evidence missing**. I address other violations, my her demands on my time and aviation safety, past ASAA violations and their attitude, my relationship with Hoy, etc. 4.5 hours to complete.
6-6-97- Hoy tells me **Livack is very upset with me** because she received a fax from ASAA objecting to my proposed withdrawal of low minimum approach at RENO. (ASAA is refusing to train).
6-8-97- memo to Linkert asking for a letter from OIG to 4 inspectors requesting cooperation in an investigation (to be protected under whistleblower). I send message that **retaliatory actions** are commencing.
6-9-97- two E-mail's to Todd Zinzer, OIG headquarters, asking for **help and protection.**
6-9-97- telecon between me and Jim Kelly, PASS VP. Tells me I should document everything that is happening in PTRS. I do.
6-9-97- Grant Pearsoll, PASS, met with Brad Pearson. **Pearson said they were after "my blood this time." (Implied threat).** *He told Pearsoll that I "better be able to prove I am right this time."*
6-10-97-Hoy tells me not to talk to anyone outside CMS about any safety issues, especially Owen Dullaghan. (Owen had called Hoy to tell him he needed to take action on Reno training, Hoy told me not to take action). Not in accordance with PD.
6-10-97- Meeting Livack, Hoy, Franklin, and I. Hostile. **She tells me to stop filing grievances** and get back to work. Won't let Franklin speak, even though he is PASS rep.
6-11-97- I send copy draft LOFT violation letter to Hoy. **Violation follow up never occurs** after I am removed. Included Lloyd letter of 4-9-92.
6-11-97- Guy Gardner, new DOT AVR-1. Tells employees paying pax. are our customers, not companies. Later he ignores my safety complaints.
6-11-97- Owen Dullaghan calls and informs me that FAA mngt. knows about our OIG visit and whistleblowing. He hears it at headquarters. **Officials making threats to take care of me.**
6-11--97- I sent Hoy objection to allowing Overman to work for other offices-we need his work.
6-12-97- I find fax copy of my letter to Ed White about Lori Anderson/Jewett, dated 4/25/97. Hoy upset.
6-12-97- my **LOFT non-compliance letter to ASAA.**

6-12-97- me to Livack about requested information. I address things hindering us from our jobs.
6-13-97- I again ask Hoy for guidance.
6-14-97-L-. John E. Gustafson writes letter to ASAA CEO, John Kelly, concerning falsification of maintenance records. Sends copy to FAA.
6-14-97 -Livack writes me memo **accusing me of creating hostile work environment for Hoy**.
6-16-97- from Owen Dullaghan to me addressing Reno safety issues.
6-16-97- from Gibson about hindrances.
6-16-97 - with Mike Coffey of AFS-200 about ASAA's refusal to train pilots. He said I should revoke the operations specifications.
6-16-97-letter to withdraw Reno ops spec. At this time Phil knew I was going to be removed. (Ultimately, change was not made as far as I know).
6-16-97- another computer recordkeeping letter written with a 30-day notification by me. This was not follow up on after my removal.
6-17-97- me to Coffey, headquarters, about RNO. I will go along with ANM-230 and management team about RNO. *(Teamwork)*
6-17-97- I ask Phil to please tell ASAA that work is not getting done because the FAA mangt. continues to "loan" my inspectors out to other sections.
6-18-97 - My letter to Dean Schwab about ASAA failure to get training approved in a timely manner, failure to submit QTR's for approval.
6-19-97- Franklin and I ask Swanigan again to make specific complaints. He refuses.
6-19-97 - Livack faxes my CEO letter to Pearson. **Pearson later tells PASS that that is when he decided to get rid of me, even though they never talked to me about the letter, and Livack stated it was within my job description.**
6-20-97- meeting with Ford and Vanderpool of Security about Jewett's investigation. **They warn me to be very careful and take good notes. They said SEA FSDO management not to be trusted**. They were interested in Duchnowski's conflict of interest (prev. POI soliciting job with ASAA, FAA overlooking).
6-20-97- message from me to Hoy asking that he get the computer recordkeeping letter out (since it has been 2 months already, and ASAA has falsified and destroyed records). Hoy knew I was going to be removed at this point.
6-23-97- Me to Jim Vanderpool of FAA Security about **missing evidence** taken from Les Martin's line check violation package.
6-23-97- message from me to Marla (typist)- **Hoy "lost" recordkeeping letter**.
6-24-97- Ops inspectors have meeting about line check. Our investigation is concluding that ASAA "intended" to operate contrary to FAR's.
6-25-97- meeting between Vanderpool, Franklin, and I about ASAA line check falsification. Vanderpool **agrees it is falsification of records.**
6-25-97- After I returned from meeting with Security, several supervisors inform me Phil looking for me. They knew I went to Security.
6-25-97- I send memo to inspectors stating Vanderpool's findings and discussion.
6-26-97- Dean Schwab informs me all ASAA management instructed to provide Hoy copies of all correspondence sent to me.
6-25-97- I inform Security of Les Martin's **missing evidence in his line check package**.

6-26-97- Memo from Livack to me reassigning me to the regional office. Given to me by Phi Hoy. Cites erroneous reasons. **Claims it is not disciplinary, but appears to be so**. Says I file too many grievances and cause him too much work, and he couldn't take me any longer. For the past several months Hoy consistently told me he would support me in my job as POI.
After my sudden removal as POI of Alaska Airlines, the FAA didn't stop the harassing and threatening actions against me. They continued to charge me with false allegations, such as misuse of government funds. They continued to discredit me and attempt to ruin my reputation. The significance is that the remaining inspectors saw the lengths that FAA management would go to in order to ruin somebody. It is certainly feasible that they would then "no find problems" at ASAA to avoid the same treatment. Shortly thereafter, the B-737 APM and APOI were also reassigned. The remaining MD-80 APM had several disciplinary actions taken against him- one for interaction with a ticket agent, a charge again brought against and inspector by ASAA, and one for a Russia flight.

Subsequent to my removal, I made the situation well known to the FAA Hotline, my elected representatives, OIG, and other avenues. I believed that safety was being jeopardized at the whims of Alaska Airlines. Many of the open safety items "disappeared" or were never follow up upon.
6-26-98- Hoy tells other inspectors not to talk to me or have me around CMS and ASAA.
6-26-97- Hoy tells Martin he is now POI. Martin says, "Good. There's a few things I would like to tell ASAA." Hoy retracts assignment and assigns Overman, who wants the job permanently and would be inclined to be more lenient.
6-26-97- memo-me to Vanderpool asking not to drop the line check falsification violation even though I had been removed.
6-27-97- no desk for me in Region for 8 months. Had to borrow space.
6-27-97-Dale Peterson, ASAA apparently knew before me about removal. Lew Richardson re: embarrassing message being put out by ASAA (Mike Swanigan) about my removal.
6-27-97- Les' **"missing evidence" showed up on his desk.**
6-27-97- Steeb overhears Hoy tell Martin, "I can't work with her anymore. I don't want her around the carrier."
6-27-97- from Pete McHugh - **he has documented a great deal about the SEA FSDO and their interference in safety issues.**
6-27-97- Dullaghan tells me **headquarters knew about OIG visit long ago.**
6-28-97- memo me to Zachary asking for transition period to train new POI (safety). Hoy refused.
6-30-97- memo to Zinzer about management interference in violations.

July 1997
ASAA Summer 1997 Newsletter is released, with article about new POI, Dennis Overman, how great he is, and how they are now about to get the lower RNP minimums for Juneau. (I had not lowered them due to ASAA's failure to train and submit data required).

7-1-97- from Pete McHugh to Glenn telling him AVR-1 wants an impartial "team" to do an on site investigation into the SEA FSDO events. (Ultimately they send one guy who is not impartial)
About 7-7-97- Franklin tells me that **he is under investigation by FAA for ASAA agent interaction**.
7-8-97- headquarters staffer, Kathy Hakulah, says I "press too hard" on issues.
7-8-97- Dennis Overman tells me he asked Hoy to allow me to help him transition, Hoy said he didn't want me around CMS or ASAA, although I had the historical knowledge.
7-9-97- my message to Guy Gardner re: removal and safety issues. Violations. Enclosures list.
7-10-97- my removal as POI and surrounding circumstances. 2nd fax with a letter attached to Mr. Guy Gardner.
7-13-97- me to Zachary again addressing transition and safety issues, lack of experience of new POI.
7-14-97- Zachary re: rush directive to move me to region, due to sensitivity of issue.
7-15-97- Livack bad mouthing me to FSDO employees.
7-16-97- conv. Martin and Hoy re: no violation at ASAA on line checks.
7-16-97- meeting with Zachary about Hoy burying line check, safety issues.
7-16-97- memo from me to CMS personnel about the meeting Franklin and I had with Vanderpool about the falsification case. Vanderpool agreed that falsification of records took place.
7-17-97- Martin conversation, re: ASAA destroyed records of investigation contrary to instructions by him. **Hindered the investigation. Hoy would not take any action.**
7-17-97- I send message to Dennis Overman about the list of ongoing/open ASAA projects. He later gets award. **His PTRS do not show any follow up**.
7-18-97- of a meeting I had with Vanderpool about ASAA destroying records in the falsification case as per Les Martin. Me told me that Hoy, Livack, and Keeton Zachary had been in his office that morning and were upset about my 7-16-97 memo. We also discussed Phil's interference with the LOFT violation, and **Dennis Overrun's falsification of his T&A with Hoy's knowledge**. Security investigated, but no follow up actions by Hoy.
7-18-97- concerns ASAA falsification, inexperienced replacement, etc.
7-18-97- Tom Anderson tells Glenn to back off and not get involved in wives issues. Cautions him. (Perceived as threat)
7-18-97- Patty Murry, Slade Gorton complaints.
7-19-97- to Valerie Veney forwarding two complaints.
7-21-97- I supplied Vanderpool with witness evidence of Overman's T&A falsification. Also on 7/25.
7-23-97- to Vanderpool stating Martin discovered line check violation even worse. Found 3 pilots who flew before recorded line check (with pax.)
7-28-97- Hoy investigating Steve F. alone at ASAA.
7-29-97- to Zinzer informing him of my **removal, and retaliation**.
7-29-97- Steeb re: **Hoy called Swanigan and said, "you are off the hook". (?!)**

August 1997

8-1-97- Swanigan appears to take credit for my removal, as per Lew R. (also see 22nd). Lew says Swanigan and Livack "big buddies" now.
8-11-97- I write to Brad Pearson about cancellation of facilitated meetings, safety.
8-14-97- Hoy informs PASS that my reassignment was because of my inability or unwillingness to perform my job adequately. (In my opinion, it was my unwillingness to ignore safety issues)
8-18-97 to March-98- around this time **Hoy starts harassing me** about the ASAA simulator. It ends up in a Security investigation.
8-18-97- while in Florida last week, Angela Elgee informed me type of questioning during manager interview. She said it was clear that mngt. wanted someone who was willing to do a hatchet job. Livack was hired. Charlene Pagan witnessed.
8/19/97- Hoy "bashing" me to Franklin (his words). Steeb says Hoy will not allow me to move with CSET team because I am "too disruptive".
8-25-97- Franklin gets letter of reprimand as a result of ASAA complaint. Livack thinks Franklin supports me too much.
8-27-97- conv. Overman re: ASAA's continued failure to submit training programs ahead of time. Training with unapproved program.
8-29-97 - receives a response from Hoy dated 7-9-97. States that my removal driven by "needs of CMS". (him) States action was not promotion, ***and FAA does not have a concern about the messages it sends to the carrier.*** (Later John Fowler tells FAA who ASAA wants in a maintenance position- message loud and clear)
8-31-97- Franklin visit, re: Swanigan approached him about coming to work for ASAA. (Another set up for conflict of interest?)

September 1997
9-1-97- Letter from Owen Dullaghan to Tristin Linkert about my safety history, FAA headquarters knowledge of our visit to OIG, and comments from headquarters officials that I could expect some sort of action taken against me.
9-2-97- Hoy working very hard to get Gibson out of ASAA section.
9-4-97-Message from me to Pearson about discontinued "safety" facilitated meetings. (They were only a facade to have me removed).
9-4-97- message from me to Vanderpool about Dennis Overman receiving cash award this morning. *(Cash award was for Overman solving all the problems I made, according to Hoy. All the* ***compliance and safety problems suddenly "disappeared")***
9-5-97- Franklin files grievance on disciplinary action Hoy took for Franklin making an ASAA agent do her job as per regulation.
9-10-97- Streeter tells me of conversation with Gary Livack. Livack claims his wife was sent to Seattle to get rid of me by Pearson and Headquarters.
9-10-97- to OIG from me about Streeter's conversation with Gary Livack about being sent to SEA to remove me and a conversation I had with Angela Elgee in Florida about Pearson's line of questioning for SEA FSDO manager position
9-11-97- Record of conversation, Glenn Diefenderfer with Dale Peterson of ASAA. About how certain ASAA personnel intentionally misquote FAA inspectors to stir up management.

9-12-97- Overman hasn't done any of project list I sent. There are follow up items to self-disclosures and violations on this list. I doubt they were ever done, giving ASAA what they wanted- **an end to corrective action**.
9-12-97-ASAA chief pilot fired supposedly for admitting line check violation.
9-17-97- Franklin and Gibson inform me they observed ASAA instructor allowing students to sign the class roster for the previous day- this is what caused 1st falsification and the "required fix" does not allow late sign ins. He said he told Hoy, Hoy just shook his head. (ASAA needs change to record requirements!)
9-19-97- Hoy informs Gibson he is being moved. (He goes to stay in bargaining unit)
9-22-97- Pearson to me re:9-4 memo. Inspectors wanted to discontinue (they did also when I was there). ASAA told FAA they wanted inspectors in facilitation, FAA went to ASAA to get permission to stop meetings.
9-25-97- Harn hired as POI.
9-29-97-During an informal telecon with ASAA, **Hoy advised Martin it is his "best interest of his career" to leave section**. **Hoy said inspectors have been too heavy handed**.

October 1997
10-1-97- Robert Hanson, AFS-400, sends message to FAA mngt. thanking me for assistance in developing RNP guidance and addressing issues. FAA never relays thanks.
10-1-97- met Pearson in hallway, he asks me if I am hiding violations. I told him the things and safety issues I am concerned about.
10-2-96- Pearson sends me message asking me to set up meeting with other inspectors. Before I can do this, I am informed Mr. Dave Thomas will be in town to gather safety issue evidence. This took place of meeting with Pearson (10-6). I did send Brad message on 10-10 forwarding copy of Thomas list. Brad says there is no longer need for a meeting.
10-7-97- Steeb witness' Hoy saying line check violation was "ridiculous" and didn't want Livack to sign it. He was looking for violation package.
10-6 to 9-97- Mr. Dave Thomas arrives and conducts employee interviews. He *did not take notes* and said he *would be not reporting in writing*. This appears to be another exercise in futility. I supply him with several page list of issues and problems, and much documentation.
10-10-97- from Pete McHugh. **Dave Thomas avoids politics**, not too supportive of Juneau Study, which was very political.
10-17-97- Larry Bird said he was witness, as acting ANM-201, of **Hoy and Livack coming to Pearson to have me removed.** It was his opinion that Hoy was afraid of me.
10-20-97 - Hoy to 2 APM's. Exclusion from ASAA meetings (*teamwork!*)
10-21-97 - headquarters official, Bob Hanson asking probing questions about my removal, Livack's history. He is eventually told to mind his own business. So is Streeter.
10-21-97- Pearson's permanent selection as Division Manager.
10-21-97- Don Streeter, headquarters, to higher headquarters officials about my memo to Beaudette, and supporting me. He is told to mind his own business.
10-24-97-Assoc. Adminin of Accident Investigation Report by Dave Thomas as a result of 7/7 and 7/10 hotline complaints.

10-24-98-10-24-97-cc- to me from Beaudette, he will forward my request for invest. and concerns to Dick Gordon for follow up. (None). He forwards on 10/28.
10-27-97- Dale Peterson informs me that ASAA officials saying Franklin about to be removed. (Hoy appears to be attempting with Russia trip)
10-28-97- message to Legal about ethics, inspectors reporting under law and mngt. attempting to punish the reporter.

November 1997
11-7-97- response from AVR-1 Guy Gardner concerning Dave Thomas' investigation and report. Not good for the good guys.
11-11-97- conv. Martin re: line check violation package back on his desk. **Management insisting he change it so it looks like he dropped it. Hoy on Steeb's case about her causing him too much work. (This is what he accused me of when he removed me)**
11-13-97- Les tells me and others mngt. is really on his case to close line check violation with no action. See Legal document.
11-17-97- Dullaghan tells me **Streeter is threatened**.
11-18-97- Tristin Linkert, OIG, conv. Hoy really trying to confuse the line check issue. Meeting held between inspectors and mgt. about case.
11-20-97- follow up meeting with Security. Placing **Hoy under investigation**. Says mgt. turns blind eye on each other. He says it appears D.O.'s award letter is also a falsification of records, based on erroneous dates. Nothing is done.
11-20-97- I rebut Thomas' report. I send copy to OIG, Tristin Linkert, and Guy Gardner.
11-7-97-Gardner memo to me re: Thomas findings resulting from 7 &11 hotlines
11-20-97- -My memo to hotline, re: Thomas report.
11-21-97 - I forward message re:Overman training, t&a

December 1997
12-3-97- report from FAA Security to Flight Standards re:Gibson conflict of interest. **Report states appearance of ASAA influencing FAA mangt.** ASAA personnel lied about Jewett.
?2-3-97- sent mssg. to Security about Harold Hutchins catching FAA mngt. falsifying records. (Also, Paul Haagland had similar experience several years ago. FAA supplied Errol Van Eaton's attorney, B.V., with false information).
12-4-97- conv. with Hubbard re: **Harn is really a problem. Doesn't realize the impact of his leniency.**
12-31-97- I file hotline about Hoy's handling of ASAA concerns in Russia. This situation demonstrates how poor a supervisor Hoy is and how he lies. The "critical de-icing issue" in Russia were never followed up upon, or relayed to ASAA.

January 1998
1-5-98 until 2-27-98, I was under investigation on charges of fraud, waste, and abuse brought on by SEA FSDO management. I was cleared. *(would other inspectors in the CMS want to endure this for finding problems?)*
1-7-98-Martin questioned by Livack about his departure. **He says Phil told him to leave section** permanently during meeting with ASAA about violation.

1-8-98-Steve Franklin has conversation with ASAA Scott Thomas. Scott says Mike Swanigan is very pleased with the new FAA team he has in place now.
1-15-98- message from me to Guy Gardner about hotline answer, clarifying their misinformation. cc: to Peggy Gilligan, she then stated she would pursue. Copies to Security, OIG.
1-28-98- Harold Hutchins visited IG about similar FAA mngt. cover-ups recently on his carriers. He was removed. Told to ignore.

February 1998
2-17-98 - Swanigan asked Franklin when he was going to come to work for ASAA. Setup?
2-25-98 -Pearson announces Angela Elgee as ANM-201. In fall 1997, while at CSET training in Florida, Angela informed Charlene Pagan and me that it was apparent by questioning of prospective SEA FSDO managers; Pearson was looking for "hatchet person".
2-25-98-PN- conv. Blake and Pierre, Tramco threatening to go to the FAA to have Pierre removed.

March 1998
3-2-98- conv. Hugh Ford. Tells me invest. into Overman complete. Couldn't give me details but whole thing stinks. Phoned OIG in front of me and said it. Nothing is ever done.
3-3-98- Steeb attends ASAA training, ASAA promoting that they follow their own set of rules, contrary to regs.
3-13-98- call from George Darrough about call to Bird. Bird says **SEA FSDO management definitely out to get me.** He said mgt. harassing me and he didn't know what he could do about it.
3-16-98- Ford wrote 5-page document to Pearson outlining and criticizing SEA FSDO management.
3-30-98- Steve Franklin informs me that Overman did not get any punishment for falsifying T&A.
3-31-98- message from Dennis Harn indicating ASAA still ignoring training programs-same issues I addressed previously. Gibson and Franklin concur.

April 1998

4-2-98- conv. Les Martin. He attended meeting back in fall where Dave Strelinger, chief pilot ASAA, admitted to not giving line checks. Hoy informed Les it would be in "his best interest" to leave the ASAA section.
4-4-98- Telecon with Lynn Pierce. Said Larry Bird and Dick Dutton claim they will not hire me on CSET because I am a "trouble maker".
4-7-98- Gibson has meeting with Livack about 10-month-old investigation into conflict of interest. Livack states the conflict of interest is not a problem, but Gibson may be punished for "intimidating" a check airmen (one that Gibson had worked with for years!)

May 1998

5-8-98- Conv. Bill Blake re: how **Pearson lied and created documents to fire Gene Dunham. Bill and others were asked to do illegal setup actions.**

5-11-98- Franklin informs me that **he is under threat of disciplinary action for speaking to me.**

1998/1999

Without going into detail, during this time period I was retaliated against over and over to the point that I had to leave the FAA. My punishment ranged from admonishments, to a letter of reprimand for exercising my right to tell my story to the press, to a proposed 14 day suspension for being on medical leave and under doctors care. The FAA revoked my FAA 3rd class medical without examination or justification. The FAA, as provided for under the law, ignored my appeal.

I also received a notarized statement from Harold Hood. His statement indicated that he met with Ed Duchnowski, who relayed that **Bill Baldwin approached him in 1997 to have me removed from the POI position.** Baldwin allegedly told Duchnowski that if he made false allegations against me, he would help Duchnowski get a higher paying position with ATA.

2000

I am informed by Lew Richardson of a conversation with Dave Strelinger. In that conversation, Strelinger told Richardson of a meeting in DFW with Swanigan and other airline VPs/Chief Pilots, where the subject **of "how to get the POI removed"** took place. Strelinger said the **decision was made by Swanigan to commence action against the POI at that meeting**, and it began upon return to Seattle.

Summary:

When an individual works for the FAA, he/she must choose one of two paths- to fail with truth, or succeed with fraud. I chose truth.

Items of Proof:

The attached items are not all the items of proof available. These items are show evidence of FAA management's attempts to interfere and/or intimidate inspectors. Some items show ASAA's attempts to eliminate the effectiveness of FAA inspectors.

- Alaska Line vodka de-icing article, record of conversation
- Record of conversation, Keeton Zachary and Bill Baldwin
- Bill Whitaker record of meeting
- Jewett Gibson FAA Security report
- E-mail to Brad Pearson
- Record of conversation between Steve Franklin and ASAA check airmen
- PTRS entries
- Harold Hood statement
- Inspector message to AFS-1, re: Value Jet
- Any last minute documents not listed here

The information presented is accurate to the best of my recollection, records, and personal notes. The incidents occurred on or about the dates presented.

This information is presented to assist the NTSB with their investigation of ASAA 261. This information shall not be used by the FAA in any litigation involving myself.

Witness contact numbers will be provided upon request.

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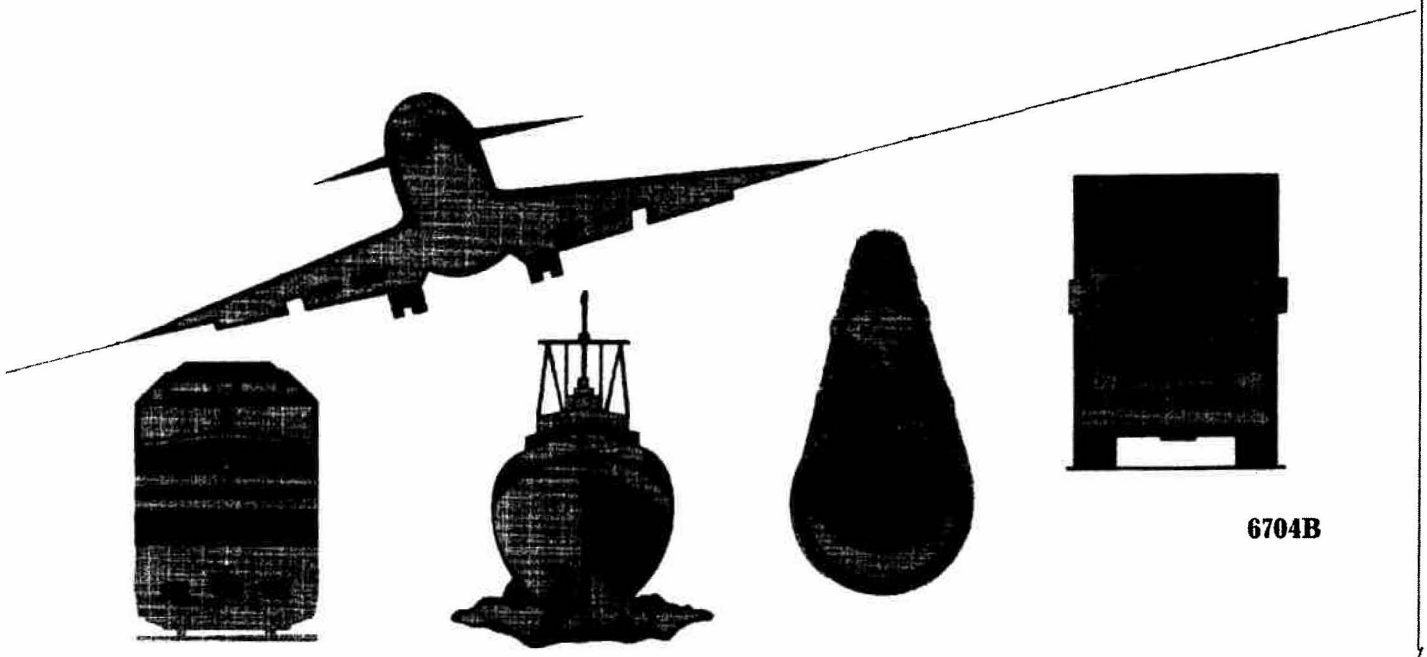
PB97-910406
NTSB/AAR-97/06
DCA96MA054

NATIONAL TRANSPORTATION SAFETY BOARD

WASHINGTON, D.C. 20594

AIRCRAFT ACCIDENT REPORT

IN-FLIGHT FIRE AND IMPACT WITH TERRAIN
VALUJET AIRLINES FLIGHT 592
DC-9-32, N904VJ
EVERGLADES, NEAR MIAMI, FLORIDA
MAY 11,1996



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NTSB/AAR-97/06 PB97-910406

NATIONAL TRANSPORTATION SAFETY BOARD

WASHINGTON, D.C. 20594

AIRCRAFT ACCIDENT REPORT

IN-FLIGHT FIRE AND IMPACT WITH TERRAIN
VALUJET AIRLINES, FLIGHT 592
DC-9-32, N904VJ
EVERGLADES, NEAR MIAMI, FLORIDA
MAY 11,1996

Adopted: August 19, 1997
Notation 6704B

Abstract: This report explains the in-flight fire and impact with terrain of ValuJet Airlines flight 592, a DC-9-32, N904VJ, in the Everglades near Miami, Florida, on May 11, 1996. Safety issues discussed in the report include minimization of the hazards posed by fires in class D cargo compartments; equipment, training, and procedures for addressing in-flight smoke and fire aboard air carrier airplanes; guidance for handling of chemical oxygen generators and other hazardous aircraft components; SabreTech's and ValuJet's procedures for handling company materials and hazardous materials; ValuJet's oversight of its contract heavy maintenance facilities; the Federal Aviation Administration's (FAA) oversight of ValuJet and ValuJet's contract maintenance facilities; FAA's and the Research and Special Programs Administration's (RSPA) hazardous materials program and undeclared hazardous materials in the U.S. mail; and ValuJet's procedures for boarding and accounting for lap children. Safety recommendations concerning these issues were made to the FAA, RSPA, the U.S. Postal Service, and the Air Transport Association.

EXECUTIVE SUMMARY

On May 11, 1996, at 1413:42 eastern daylight time, a Douglas DC-9-32 crashed into the Everglades about 10 minutes after takeoff from Miami International Airport, Miami, Florida. The airplane, N904VJ, was being operated by ValuJet Airlines, Inc., as flight 592. Both pilots, the three flight attendants, and all 105 passengers were killed. Visual meteorological conditions existed in the Miami area at the time of the takeoff. Flight 592, operating under the provisions of 14 CFR Part 121, was on an instrument flight rules flight plan destined for the William B. Hartsfield International Airport, Atlanta, Georgia.

The National Transportation Safety Board determines that the probable causes of the accident, which resulted from a fire in the airplane's class D cargo compartment that was initiated by the actuation of one or more oxygen generators being improperly carried as cargo, were (1) the failure of SabreTech to properly prepare, package, and identify unexpended chemical oxygen generators before presenting them to ValuJet for carriage; (2) the failure of ValuJet to properly oversee its contract maintenance program to ensure compliance with maintenance, maintenance training, and hazardous materials requirements and practices; and (3) the failure of the Federal Aviation Administration (FAA) to require smoke detection and fire suppression systems in class D cargo compartments.

Contributing to the accident was the failure of the FAA to adequately monitor ValuJet's heavy maintenance programs and responsibilities, including ValuJet's oversight of its contractors, and SabreTech's repair station certificate; the failure of the FAA to adequately respond to prior chemical oxygen generator fires with programs to address the potential hazards; and ValuJet's failure to ensure that both ValuJet and contract maintenance facility employees were aware of the carrier's "no-carry" hazardous materials policy and had received appropriate hazardous materials training.

Safety issues discussed in the report include minimization of the hazards posed by fires in class D cargo compartments; equipment, training, and procedures for addressing in-flight smoke and fire aboard air carrier airplanes; guidance for handling of chemical oxygen generators and other hazardous aircraft components; SabreTech's and ValuJet's procedures for handling company materials and hazardous materials; ValuJet's oversight of its contract heavy maintenance facilities; FAA's oversight of ValuJet and ValuJet's contract maintenance facilities; FAA's and the Research and Special Programs Administration's (RSPA) hazardous materials program and undeclared hazardous materials in the U.S. mail; and ValuJet's procedures for boarding and accounting for lap children. Safety recommendations concerning these issues were made to the FAA, RSPA, the U.S. Postal Service, and the Air Transport Association.

APPENDIX I—FEBRUARY 14, 1996, AFS-300 REPORT

VALUJET
VJ6A465W
ALANTA, GA.
2/14/96

Report prepared by
AFS-300

This report summary addresses ValuJet Airline's accident/ incidents, enforcement history, NASIP Inspections, and the FAA's surveillance activity. Airworthiness concerns following two (2) recent accidents and a DOT Office of Inspector General (OIG) audit of the air carrier are the catalyst of this analysis.

ValuJet was originally certified as a domestic air carrier (121) on October 21,1993. Their certificate number is VJ6A465W. ValuJet will be addressed as VJ6A throughout the remainder of this report.

Their principal base of operations is Atlanta, Ga. Additionally, they operate two (2) maintenance facilities at the Hartsfield Airport, Atlanta, Ga. and Dulles Airport, Va.

General Information:

VJ6A has an adequate management staff that consists of

CEO
General Manager
Vice President of Maintenance
Director of Maintenance
Chief Pilot
Director of Operations
Chief Inspector
Director of Aircraft Programs
Director of Technical Services
Director of Safety

The VP of Maintenance, Director of Technical Services, Director of Aircraft Programs, Chief Inspector, and Director of Safety are recent additions to the management staff.

VJ6A principal inspectors consider all individuals well qualified for their positions.

VJ6A'S Certificate is managed by the ATL-FSDO, College Park Ga. The Principal FAA Inspectors are:

PMI	David J. Harper
POI	Robert E. Bruce
PAI	David L. Frantz

VJ6A employs approx. 142 captains, 17 check airman, 4 designated inspectors, 170 pilots, 450 flight attendants, 156 A&P mechanics, 137 ground personnel, and numerous other staff and service personnel.

The primary training location for pilots, flight attendants, and mechanics is Atlanta, Ga.

VJ6A operates 34 DC-9-30 series aircraft and uses contract maintenance facilities for **scheduled and unscheduled maintenance** away from their main base in Atlanta and the sub-base at Dulles.

Contract Maintenance Organizations:

1. AMR Combs	Windsor Lock Ct.
2. Signature Flight Services	Boston, Ms.
3. Lane Aviation	Columbus, Oh.
4. AMR and NWAA	Dallas, Tx.
5. Jet Center	Fort Lauderdale, Fl.
6. USAIR	Oakland, Ca.
7. David Yocum	Kansas City, Mo.
8. North West	Orlando, Fl.
9. Signature Flight Support	Chicago, IL.
10. North West	Memphis, Tn.
11. Continental	New Orleans, La.
12. Continental	West Palm Beach, Fl.
13. Rick Aviation	Newport news, Va.
14. Northwest	Philadelphia, Pa.
15. Jet South	Fort Myers Fl.
16. AMR	Savannah, Ga.
17. Northwest	Tampa, Fl.

The company phone number is (404) 907-2580.

ACCIDENT/INCIDENT:

Accident History:

1. July 5, 1994 aircraft encountered moderate chop at cruise. One (1) cabin crew member suffered multiple leg fractures no fatalities. The NTSB investigated and determined probable cause as severe turbulence over flight area.

2. June 8, 1995 aircraft experienced a uncontained turbine failure during takeoff roll at Atlanta's Hartsfield Airport, Ga. Five (5) passengers and one (1) cabin crew member were injured no fatalities. The NTSB is investigating, with no probable cause reported.

3. January 7 1996 during an attempted landing at Nashville, Tn. the aircraft sustained damage to the nose landing gear. The aircraft departed the runway, circled and landed with no nose landing gear. NTSB is investigating, with no probable cause reported. No fatalities or injuries reported.

Incident History:

VJ6A had a total of nine (9) incidents since 1994 with the last one occurring in December 1995.

VIOLATION HISTORY:

VJ6A has a total of 46 violations since 1993 with 20 violation remaining open. Approx. Six (6) of the violations were maintenance related. The FAR's violated are; 43.9, 43.13, 121.363, 121.367, and 121.369. No accidents were related to any of these violations.

All maintenance related violation were closed with administrative action (letter of correction). In an analysis of the enforcement action it was noted that a violation of FAR 121.363 occurred two (2) times in less than one (1) year and both closed with letters of correction.

FAA Order 2150.3A specifically states that the letter of corrections sole purpose is to correct conditions which are in violation of the FARs. With the second violation of FAR 121.363 occurring within one (1) of the first violation it appears that the corrective action was not adequate.

NASIP:

A NASIP was performed at VJ6A in September 1995. A total 58 findings were noted. The category are:

1. 17 Category A
2. 17 Category B
3. 24 Category C

43 of the 58 findings were maintenance related. While the inspection was completed five months ago, 43 findings have not been closed.

The significant maintenance related NASIP findings are:

Manuals and Procedures:

1. Eleven findings were noted with the document that outlines the continued analysis and surveillance program (CAS). The significant findings include:

- Problems with CAS forms numbering system
- CAS does not address engine trend monitoring
- Maintenance Manual conflicts with CAS document
- CAS program not accepted by the FAA

- CAS does not outline audit function
- CAS does not address emergency response
- CAS reference a reliability program, however, VJ6A has none

2. Fifteen findings were noted with the General Maintenance Manual (GMM) and related documents. The significant findings include:

- GMM conflicts with FAR requirements in several areas
- Fuel Manual not adequate, several important items omitted
- GMM has conflicting chapters
- GMM does not establish guidelines for RII training
- Winter Ops. Manual reference incorrect information on de-icing fluids
- Maintenance Check Manual not current in Maint. Planning Dept.

Records Systems:

3. Two findings were noted with the records system they are:

- No engine condition monitoring records
- CAS reported a maintenance problem, however, no records were found correcting problem

Maintenance Facilities:

4. Nine findings were noted in the area of Maintenance Facilities. The significant findings include:

- Parts found in bins without records
- Parts not identified IAW GMM
- A system not outlined in the GMM used to track returned parts to stock
- Part scrapping procedure not addressed in GMM

Ramps and Spots:

5. Four findings were noted in the area of ramps and spots. The significant findings include:

- MEL procedure not followed
- Performing maintenance without adequate facilities
- Performing maintenance with unapproved procedures

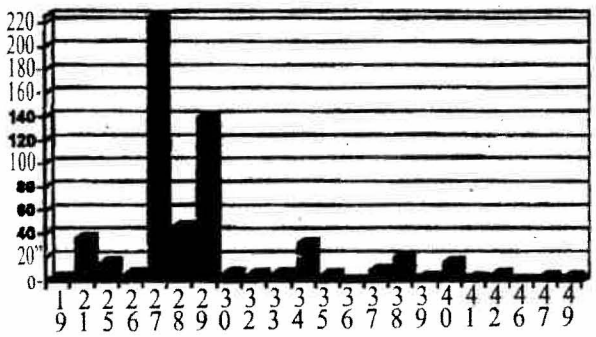
FAA SURVEILLANCE HISTORY

The following is an analysis of two (2) years of VJ6A's surveillance activities. The data was obtained from the National PTRS. 22 air carrier specific inspection items were analyzed. They are identified by the surveillance codes as they appear in the PTRS Manual.

A reference table is provided below the histogram that identifies the PTRS Code with the actual inspection function. Example; Number 27 on the chart is a ramp inspection that was accomplished 226 times in two (2) years.

The histogram clearly shows that the most accomplished inspection is the ramp inspection PTRS Code 3627 and the least accomplished is the structural inspection PTRS Code 3646.

PTRS DATA FOR FY 94 & 95



Reference:

19. = Main Base	3619 = 003
21. = Line Station	3621 = 036
25. = Air Operators Special Inspection	3625 = 015
26. = Manuals and Procedures	3626 = 006
27. = Ramps	3627 = 226
28. =Spot	3628 = 046
29. = En Route	3629 = 141
30. = En Route Cabin	3630 = 006
32. = Shop/Facility	3632 = 005
33. = Training Records	3633 = 006
34. = Aircraft Records	3634 = 031
35. = Continuing Analysis	3635 = 005

36. = Reliability Program	3636 = 002
37. = Inspection Program	3637 = 009
38. = Fuel Facility	3638 = 020
39. = Approved Weight & Balance	3639 = 003
40. = Contract Maintenance Facility	3640 - 015
41. = Maintenance Support Facility	3641 = 002
42. = Technical Manuals	3642 = 005
46. = Structural Inspection	3646 = 000
47. = Structural Spot	3647 = 003
49. = Airworthiness Directives	3649=003

A total of 588 inspection items were recorded by the certificate management office and geographic inspectors during the work program years of FY 94 and 95.

Of the 588 inspections 359 were satisfactory eight (8) were not accomplished, eight (8) were canceled "X-out", 207 recorded some discrepancy, and **six (6) resulted in enforcement action.**

36 percent of all inspection accomplished in two (2) years recorded some findings.

It was noted that surveillance code 3636 **reliability program inspection was** recorded two (2) times with a total of 10 inspector hours charged to an air carrier that does not have a reliability program.

When comparing the NASIP findings with surveillance activities, we clearly see that areas receiving the least attention during the inspection year make up the majority of the maintenance related NASIP findings.

In addition to the PTRS information a report was run on the Safety Performance Analysis System (SPAS) for VJ6A. The report analyzed the following areas:

Records and Procedures
Airworthiness Surveillance
Aircraft Records

The report covered approx. three years of data. In all areas analyzed VJ6A was at the advisory and or alert threshold in the majority of the months studied.

Additionally, an independent regional aviation safety specialist analyzed VJ6A inspection and surveillance data with virtually the same results and conclusions as this report. This additional sources further validates our hypothesis.

CONCLUSIONS:

This report addressed VJ6A's accident/incident enforcement history, NASIP Inspection, and the FAA's surveillance activity. The data reviewed, clearly show some weakness in the FAA's surveillance.

The PTRS data analysis revealed that some critical surveillance activities did not receive much attention They are as follows:

1. Manuals and Procedures PTRS Code 3626 six (6) inspection

2. Shop and Facilities PTRS Code 3632 five (5) inspection

3. Structural Inspection PTRS Code 3646 zero (0) inspections

Although some may argue that six (6) inspections of manuals and procedures is sufficient in two (2) years, you need only look to the recent NASIP Inspection findings to see why more inspections should have been done. 35 of the inspection findings were in the manuals and procedures and shop and facilities area. Additionally, the SPAS data for procedures indicate that increased surveillance is warranted. 20 times between December 1993 and January 1996 VJ6A was at the advisory and or alert threshold.

The PTRS data also indicated that no structural inspections were accomplished on VJ6A's aircraft in two (2) years. With a supplemental inspection document (SID) required by AD 87-14-07 to **ensure continued structural integrity of an aging fleet of DC-9 aircraft,** AFS 300 believes this critical inspection was severely overlooked.

The findings closet date for the September 1995 NASIP inspection is February 28,1996

RECOMMENDATIONS:

Based on VJ6A's history, The NASIP Inspection, NTSB and OIG investigations, and Surveillance AFS-300 can recommend the following actions:

1. Consideration should be given to an immediate FAR-121 re-certification of this airline. This recommendation is based on such known safety related issues as the absence of adequate policies and procedures for the maintenance personnel to follow. Additionally, the absence of engine trend monitoring data, and the possibility of a continuous airworthiness maintenance program that maybe inadequate because it uses reliability based procedures without a reliability program.

2. The overall surveillance of the air carrier should be increased in FY96. Special attention should be directed toward manuals and procedures, structural inspections, the

adequacy of the maintenance program, and shops and facilities. Additionally, the PMI should consider accomplishing two (2) main base inspections every year.

3. The close out dead line for the NASIP inspection is February 28, 1996. Every effort should be made to meet this dead line with positive corrective action.

4. When a violation of the FARs are detected the inspector should consider past enforcement history before administrative corrective action is offered. If an air carrier violates the same regulation in a short period of time, escalating the enforcement action may be appropriate.

This report was compiled from information obtained from the national database and VJ6A's NASIP Inspection Report. A physical inspection of the maintenance manual was not conducted by AFS-330

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U.S. Department
of Transportation
**Federal Aviation
Administration**

FAA DALA CMU - North
2901 Metro Drive, Suite 500
Bloomington, MN 55425

January 26, 2010

Certified-Return Receipt

Delta Air Lines, Inc.
Mr. Tony Charaf / Dept. 217
President, Technical Operations
PO Box 20706
Atlanta, GA 30320-6001

RE: EIR File #2010SO270112

Dear Mr. Charaf:

Our office is investigating Delta Air Lines, Inc. (DALA) A-320, Ship# 3233, U.S. Registration number N333NW, operating as Flight# 2412 from Minneapolis/Saint Paul (MSP) to Cancun, Mexico (CUN) and its return as Flight # 2413 from CUN to MSP on January 20, 2010, in which certain maintenance irregularities were discovered. Specifically, there were missing fasteners on a panel from the Right Horizontal Stabilizer. Maintenance personnel were directed to the aircraft to perform maintenance in accordance with repair instructions contained in a pending Engineering Repair Authorization (ERA). This appears to be contrary to Federal Aviation Regulations.

This is to inform you that the Federal Aviation Administration is investigating this matter. We wish to offer you an opportunity to discuss the incident in person or submit a written statement within ten (10) working days following receipt of this letter. Your statement should contain all pertinent facts and any mitigating circumstances you believe may have a bearing on the incident. If we do not hear from you within the specified time, we will process this matter without the benefit of your statement.

Sincerely,

Keith A. Frable
Supervisory Principal Maintenance Inspector

File 8030-1-1
Ron/O/NWA_MAIN/8030/8030-1/2010/2010SO270112LOI.doc/clf;1/25/10

CONCURRENCES	
ROUTING SYMBOL	M-19(N)
INITIALS/SIG	
DATE	1-26-10
ROUTING SYMBOL	M-1 (N)
INITIALS/SIG	
DATE	1-26-10
ROUTING SYMBOL	OM-1 (N)
INITIALS/SIG	
DATE	1/26
ROUTING SYMBOL	ASA-CF (N)
INITIALS/SIG	
DATE	1/26/10
ROUTING SYMBOL	
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INITIALS/SIG	
DATE	

FOR OFFICAL USE ONLY

➢ ➢ ➢ REPAIR INSTRUCTIONS ≺ ≺ ≺

SHEET	1
TOTAL	1

Access panel , RH horz stab trailing edge

A/C #:	3233		
STATION:	Cancun		
ENGINEER:	Steve Wachtler		
DATE / TIME:	20Jan10 / 04:45 pm		
ER/A #: [2]	-14		
MAJOR		MINOR	X
REQUIRED INSPECTION ITEM (R.I.I.)			
YES		NO	X
AIRCRAFT SHORING REQUIRED [1]			
YES		NO	X

[1] REFERENCE APPLICABLE M/M OR SRM FOR AIRCRAFT SHORING INSTRUCTIONS.

[2] NOTE: REFER TO TOPP 40-20-70 FOR INSTRUCTIONS REGARDING AIRCRAFT DISPATCH PRIOR TO ER/A ISSUANCE. AIRCRAFT MAY BE RELEASED PRIOR TO FINAL ERA.

INTRODUCTION: Panel 344BB was found hanging down from its hinge. Missing all 16 screws that hold it shut. All other surrounding panels are intact per print. No other damage was reported due to door being open.

NOTE: A permanent repair will need to be accomplished within one cycle. ER/A 479353-14 will track this requirement.

INSTRUCTIONS:

1. Visually check hinge fasteners for security in panel 344BB. Perform a general visual check of all surrounding structure for additional damage.
2. Remove two screws from panel 344CB one from inbd and one from outbd.
3. Install these two fasteners in panel 344BB, at the aft most positions. One inbd and one outbd
4. Clean all surfaces for the application of speed tape.
5. Apply speed tape to both 344CB and 344BB panels. Maintain a 2 " min overlap both directions beyond each gap. Speed tape the fwd side of each panel also.
6. New screws must be installed within one cycle.
7.
8.
9.
10.

DELTA	Engineering Repair/Authorization	No. 479353-14	Rev. Original
Title: Access panel, lower RH horz. Stab trailing edge, 344BB<< time limited >>		File Code 55-10	Sheet 1 of 3

Effectivity Information

Product Type	Aircraft	Aircraft	3233	Hours	53755	Cycles	24414
Customer	Delta Air Lines	Tracking #	N/A	Assembly #	N/A	Part #	D55184310
Weight Config	N/A	Job Stop #	N/A	Shop Order	N/A	Serial #	N/A

Classification Information

Category	Repair	Classification	Minor	PSE?	No	RIIs Included?	No
Warranty?	No	FCS?	No	ETOPS Affected?	No	STC?	No
Authority		14 CFR 121.379(b)		Weight Change	N/A	Wt Change Location	N/A

Engineering Information

Author	Steve Wachtler	Date	21Jan2010	Eng. Hours	
Checker	Marty Hoffarth	Date	21Jan2010	Distribution	Hgr demand plng D239
Approver	Marty Hoffarth	Date	21Jan2010	Scheduling Affected?	yes
Coordinated		Date		Rework Required?	

Time Controlled Items

Sec.	Time of Accomplishment	ACTL/Log Page #	Parts Required
I.	While in CUN	6977294/0184620	No
II.	Within 1 cycle after section I	6977294/0184620	Yes
III.			No

INTRODUCTION:
While in CUN, access panel 344BB was found hanging down from it's undamaged hinge. The attaching bolts were found to be missing, not sheared off. See figure 1 for details.

REASON: **Facilitate MTC**

INSTRUCTIONS ON SHEET 2

~

INSTRUCTIONS:

Section I: Time-Limited Repair

Aircraft	RII? **No**	SDR? **No**	Shoring Required **No**

1. Visually check hinge fasteners for security in panel 344BB. Perform a general visual check of all surrounding structure for additional damage.
2. Remove two screws (DAN169E3-8) from panel 344CB one from inbd and one from outbd.
3. Install these two fasteners in panel 344BB, at the aft most positions. One inbd and one outbd. See figure 1
4. Clean all surfaces for the application of speed tape
5. Apply speed tape to both 344CB and 344BB panels. Maintain a 2 " min overlap both directions beyond each gap. Speed tape the fwd side of each panel also.
6.
7.
8.
9.
10.

Section II: Permanent Repair

Aircraft	RII? **No**	SDR? **No**	Shoring Required **No**

1. Remove section I repair by removing speed tape and returning two fasteners to panel 344CB.
2. Install DAN169E3-8 or equivalent screws in discrepant locations.
3.
4.
5.
6.
7.
8.
9.
10.

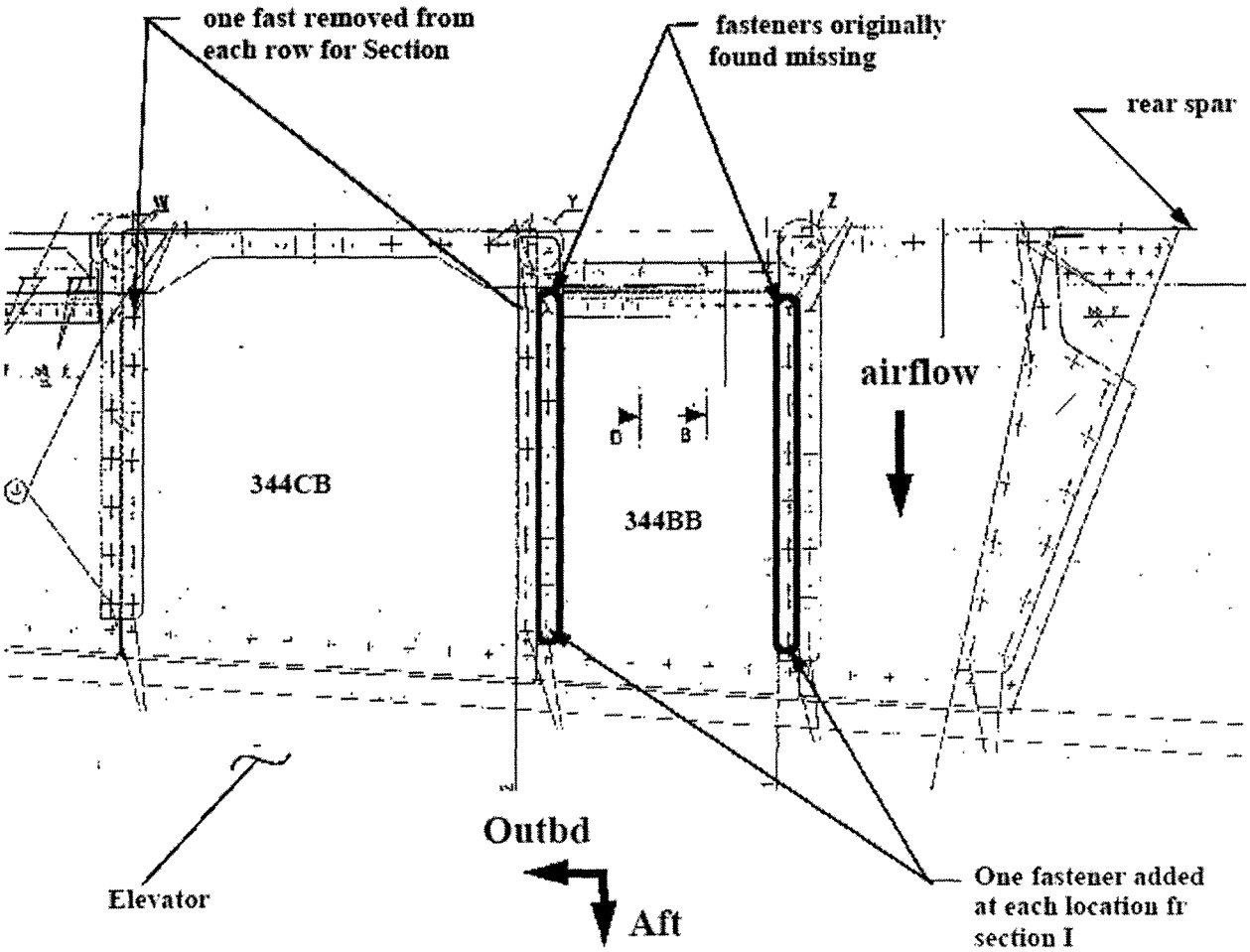

Figure 1 looking up, left side shown right side opposite

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PB92-910405
NTSB/AAR-92/04

NATIONAL TRANSPORTATION SAFETY BOARD

WASHINGTON, D.C. 20594

AIRCRAFT ACCIDENT REPORT

BRITT AIRWAYS, INC., d/b/a
CONTINENTAL EXPRESS FLIGHT 2574
IN-FLIGHT STRUCTURAL BREAKUP
EMB-120RT, N33701
EAGLE LAKE, TEXAS
SEPTEMBER 11, 1991

5612B

NTSB/AAR-92/04 PB92-910405

NATIONAL TRANSPORTATION SAFETY BOARD

WASHINGTON, D.C. 20594

AIRCRAFT ACCIDENT REPORT

BRITT AIRWAYS, INC., d/b/a
CONTINENTAL EXPRESS FLIGHT 2574
IN-FLIGHT STRUCTURAL BREAKUP
EMB-120RT, N33701
EAGLE LAKE, TEXAS
SEPTEMBER 11, 1991

Adopted: July 21, 1992
Notation 5612B

Abstract: This report explains the structural breakup in flight and crash of Continental Express Flight 2574, an Embraer 120, in a cornfield near Eagle Lake, Texas. The safety issues discussed in this report include the feasibility of developing a means to advise flightcrews of recent maintenance work on aircraft and the need for reviewing regulations, policies and practices for establishing required inspection items (RIIs) with a view toward developing more specific identification of RIIs. Safety recommendations concerning these issues were made to the Federal Aviation Administration.

EXECUTIVE SUMMARY

On September 11, 1991, about 1003 Central Daylight Time, Continental Express Flight 2574, an Embraer 120, operating under Title 14 of the Code of Federal Regulations, Part 135, experienced a structural breakup in flight and crashed in a cornfield near Eagle Lake, Texas. The 2 flight crewmembers, 1 cabin crewmember and 11 passengers aboard the airplane were fatally injured.

The National Transportation Safety Board determines that the probable cause of this accident was the failure of Continental Express maintenance and inspection personnel to adhere to proper maintenance and quality assurance procedures for the airplane's horizontal stabilizer deice boots that led to the sudden in-flight loss of the partially secured left horizontal stabilizer leading edge and the immediate severe nose-down pitchover and breakup of the airplane. Contributing to the cause of the accident was the failure of the Continental Express management to ensure compliance with the approved maintenance procedures, and the failure of FAA surveillance to detect and verify compliance with approved procedures.

The issues in this investigation focused on:

1. The responsibilities of the Federal Aviation Administration and aircraft manufacturers and operators to determine the critical items and inspection levels of aircraft systems.

2. The procedures for relaying and standardizing maintenance shift turnover information.

As a result of this investigation, the Safety Board issued safety recommendations to the Federal Aviation Administration on the feasibility of developing a means to advise flightcrews of recent maintenance work on aircraft and the need for reviewing regulations, policies and practices for establishing required inspection items with a view toward developing more specific identification of such items. Also, as a result of this investigation, on February 28, 1992, the Safety Board issued safety recommendations to the Federal Aviation Administration that would enhance both flight standards surveillance of Continental Express and flight standards Program Guidelines, including the National Aviation Safety Inspection Program.

the appropriate Federal Aviation Regulations. For this reason, it is essential that the contents be followed."

GMM 1, Section 3, Paragraph 10, specifies that it is imperative for maintenance/inspection forms to be completed to ensure that no work item is overlooked. Such work includes the completion of maintenance/inspection shift turnover forms, so that oncoming supervisory personnel can be made aware of complete/incomplete work, and the documentation of incomplete work that the mechanic can note on the reverse side of the M-602 work cards. GMM 1, Section 5, Paragraph 7, specifically addresses several methods to ensure proper turnover during shift changes. These methods include briefings by mechanics to supervisors and briefings by outgoing supervisors to incoming supervisors.

The GMM contained provisions for a lead mechanic position in the organizational structure of the maintenance department. That position was not filled at the **IAH** maintenance base. According to the FAA maintenance inspector responsible for oversight of the Continental Express maintenance facilities, the lead mechanic position was identified in the organizational structure of one of the merger airlines. That position did not exist at the other merger airline. Instead, the supervisor was assigned to perform the functions assigned to the lead mechanic. Therefore, the lead mechanic position did not exist at the **IAH** maintenance base and, according to the FAA inspector, would not be considered a deviation from or violation of the provisions of the GMM for the Houston base.

1.17.3 Horizontal Stabilizer Maintenance

The review of the maintenance records for N33701 revealed that on August 26, 1991, during the airline's fleet-wide campaign to examine aircraft deice boots for winter operation, a quality control inspector had noted both leading edge deice boots as "watch list" items on M-602 work cards because of "dry rotted pin holes entire length" [of the boots]. On September 10, 1991, the night before the accident, Continental Express' Maintenance Control office scheduled both horizontal stabilizer leading edge deice boots on N33701 for replacement.

A series of interviews was conducted from September 13 through 16, 1991, and from October 22 through 24, 199 1, with airline maintenance personnel, inspectors, and supervisors who were working the night before the accident. These personnel worked on the airplane on the second or "evening" shift and third or "midnight" shift. During the first series of interviews, seven mechanics, four maintenance supervisors, and three quality control inspectors were interviewed.

During the second series, one mechanic, one inspector, and two supervisors were reinterviewed; and two senior directors and two FAA principal maintenance inspectors were interviewed for the first time.

The interviews revealed that the night before the accident, the airplane was pulled into the Continental Express hangar at IAH during the second shift at about 2130 hours for scheduled maintenance. The scheduled maintenance included the removal and replacement of both the left and right horizontal stabilizer deice boots.

A change of either the left or right deice boot required that the leading edge/deice boot assembly for that side of the horizontal stabilizer be removed from the stabilizer. Normally, while still attached to the stabilizer, the old deice boot would be stripped from the composite structure of the leading edge, the deice fluid lines would be disconnected, and the leading edge would be removed and a new deice boot bonded on. Then, the leading edge/deice boot assembly would be reinstalled on the horizontal stabilizer by means of approximately 47 attaching screws for each of the top and bottom sides of the assembly.

Two second shift mechanics, with the assistance of an inspector, gained access to the T-tail, which was about 20 feet above the ground, by means of a hydraulic lift work platform. The work was assigned by the second shift supervisor who took charge of N33701. The two mechanics removed most of the screws on the bottom side of the right leading edge and partially removed the deice boot bonded to the front of the right side leading edge.

The inspector who had climbed on top of the T-tail had removed the attaching screws on the top of the right side leading edge and then walked across the T-tail and removed the attaching screws from the top of the left side leading edge. The bottom screws that continued holding the horizontal stabilizer leading edge assembly in place were not removed. The top sets of attaching screws for both the left and right horizontal stabilizer leading edge assemblies were not visible from the ground.

The right leading edge assembly was removed from the horizontal stabilizer following a shift change by third shift mechanics. A new deice boot was bonded to the front of the leading edge at a work bench inside the hangar. During the third shift, the accident airplane was pushed out of the hanger to make room for work on another airplane. There was no direct light placed on the airplane as it sat outside the hangar. Work on the horizontal stabilizer was resumed outside. The third shift mechanics reinstalled the right side leading edge assembly. They used

new and used screws to attach the top and bottom of the assembly to the right horizontal stabilizer.

The second shift work on N33701 was indicated on the second shift inspector's written turnover sheet; however, the incoming third shift inspector reviewed the sheet before the entry was made. The third shift maintenance supervisor and mechanics were not verbally informed of the removal of the upper screws on the left side leading edge. The M-602 work cards had originally been assigned to the third shift for completion, but the second shift supervisor, who was assigned to N33701, elected to start work on the deice boots to assist the third shift with the workload. In addition, he did not issue the M-602 work cards to the second shift mechanics because they were in a package assigned to the third shift. As a result, no entries were made on the reverse sides of the M-602 work cards that would have informed the third shift supervisor and third shift mechanics that work had been started by the second shift on both the left and right horizontal stabilizer deice boots.

A third shift inspector later reported that he had gained access to the top of the horizontal stabilizer to assist with the installation and inspection of the deice lines on the right side of the horizontal stabilizer. He stated that he was not aware of the removal of the screws from the top of the left leading edge assembly of the horizontal stabilizer. In the dark outside the hangar, he did not see that the screws were missing from the top of the left side leading edge assembly for the horizontal stabilizer.

Based on information gathered from interviews and statements, the following significant maintenance events took place the night before the accident:

2000: The second shift supervisor, who was in charge of a "C" check on another airplane, and another supervisor normally assigned to the flight line but who was to supervise the work on N33701, discussed bringing N33701 into the hangar. [There were two supervisors on the second shift. One supervisor was normally assigned to the flight line, but he took charge of the maintenance on N33701. The second supervisor was in charge of a C check on another airplane.]

2100: The supervisor who took charge of N33701 told a second shift mechanic to remove both deice boots from N33701.

2130: N33701 was brought into the hangar by the second shift supervisor, who was responsible for the C check on another airplane. A second shift inspector informed the other second shift supervisor, who was now responsible for N33701, that he would volunteer to assist mechanics with the boot changes.

2145: A third shift flight line supervisor arrived at the hangar and noted that the third shift hangar supervisor was already there.

2200: The second shift supervisor responsible for N33701 observed two mechanics and the second shift inspector kneeling on the right stabilizer removing the right boot.

The third shift hangar supervisor observed the second shift inspector lying on the left stabilizer and observed two mechanics removing the right deice boot.

The third shift supervisor, who was working the hangar, asked the second shift supervisor (who was responsible for the C check on another airplane) if work had started on the left stabilizer. The third shift supervisor observed the supervisor look up at the tail of N33701 and state "No."

The third shift supervisor, who was working the hangar, told the second shift supervisor (who was responsible for the C check on another airplane) that he would be able to change the right deice boot that evening, that the left deice boot change could be made on another night, and that he would return the left replacement boot to stock. The second shift supervisor took the right replacement boot and placed it on a work bench.

2205: The third shift inspector arrived early for work and saw that the majority of the right deice boot had been removed. He reviewed the inspector's turnover form and found no writeup on N33701 because the second shift inspector, who had removed the upper screws, had not yet made his log entries.

2215: A third shift mechanic clocked in and went to the break room to chat with friends until the start of his shift at 2230.

Shift Change

2230: The second shift inspector, who removed the upper screws from the leading edges of both stabilizers on N33701, filled out the inspector's turnover form with the entry, "helped the mechanic remove the deice boots." He then clocked out, and left for home. The inspector later stated that he placed the screws that he removed from the top row of the left and right sides of the horizontal stabilizer in a bag and that he left the bag on the **manlift.**

One of the two mechanics, who was helping with the boot change on N33701, stopped working and returned to airplane 724 to finish work that he had started earlier in the shift.

A third shift mechanic was informed by the third shift supervisor that he was assigned to do the line check on N33701, and that he needed to reposition N33701 outside the hangar. N33701 was then moved outside the hanger.

The second shift mechanic, who had been removing the deice boot on N33701, gave a verbal turnover to the second shift supervisor (who was responsible for the C check on another airplane). The mechanic was instructed by the supervisor to give his turnover to a third shift mechanic. After giving a turnover to a third shift mechanic, the second shift mechanic locked up his tools and clocked out.

The third shift mechanic, who received the turnover from the second shift mechanic, was not assigned later to N33701. He later stated that he recalled seeing the bag of removed screws on the **manlift.** The third shift mechanic gave a verbal turnover to another third shift mechanic, who later did not recall receiving a turnover and stated that he did not see any bagged screws.

Another third shift mechanic arrived at the hangar and was informed by the third shift supervisor, who was working the hangar, that he was assigned to **N33701's** boot replacement and that he should talk to the second shift supervisor to find out what had been accomplished. There was no discussion regarding which of the two second shift supervisors that the third shift mechanic should talk to. The mechanic talked to the second shift supervisor in charge of the C check on another airplane.

The third shift mechanic then asked the second shift supervisor (who was responsible for the C check on another airplane) what had been done on N33701 during the second shift. The mechanic observed the supervisor point to the tail of N33701 and say that a few stripped screws had prevented the second shift mechanics from removing the right leading edge. The mechanic then asked if any work had been performed on the left deice boot. The supervisor informed him that he did not think he would have time to change the left deice boot that evening.

2245: The third shift line supervisor left the hangar to work at the gate and had no involvement with N33701.

2300: The second shift supervisor responsible for N33701 left work about this time. He had not talked to the other second shift supervisor, the third shift supervisor, who was working the hangar, or the third shift supervisor in charge of line checks before he left for home.

2330: The second shift mechanic who helped with the removal of the right boot clocked out and left for the evening.

Subsequently, the airplane was cleared for flight. The first flight was a passenger flight from **IAH** to LRD at 0700. There is no evidence from the morning's preflight that the flightcrew knew of any of the work performed on the horizontal stabilizer. Moreover, the **FARs** and airlines did not require them to be informed of such work.

The flight from **IAH** to LRD was without incident. Shortly after the accident, a passenger, who had been on the flight from **IAH** to LRD, informed Safety Board investigators that he was awakened on the flight to LRD by

vibrations that rattled his beverage can on the meal tray in front of him. Accordingly, he asked the flight attendant if he could move to another seat. The passenger did not inform the flight attendant or any other crewmembers about the vibrations. Others passengers on that flight, some of whom had flown on that model airplane previously, did not recall unusual vibrations. The accident took place on the return trip from LRD to IAH.

1.17.4 Required Inspection Items (RIIs)

Continental Express' GMM 1 Section 5, states that "Continental Express has established a list of items that requires a concentrated inspection (RII) on any work performed on those items. This list includes items that could result in a failure or malfunction that could endanger the safe operation of the aircraft, if not properly installed or if improper parts or materials are used." On page 5-5, Paragraph 2, "Designated [required inspection] Items" the item "Stabilizers" is listed. Also, 14 CFR 135.427 states "A designation of the items of maintenance and alteration that must be inspected (required inspections) including at least those that could result in a failure, malfunction, or defect endangering the safe operation of the aircraft, if not performed properly or if improper parts or materials are used."

Continental Express' management and quality control inspectors stated that the removal and replacement of the horizontal stabilizer leading edge deice boots were not RIIs. RIIs are required to be inspected by a quality assurance inspector. However, the M-602 maintenance work order cards, used the night before the accident to assign the work to change both the left and right horizontal stabilizer deice boots, had the RII "Yes" block circled. Further, the completion of the deice boot change, the removal of the used deice boot, and the bonding of a new boot to the right side leading edge assembly were signed off by a quality control inspector on the third shift. However, the inspector stated that he knew that the boot was not an RII and therefore conducted only a cursory walk around the tail without inspecting the final installation of the leading edge/deice boot.

Embraer stated that the deice boots and leading edges, as assemblies, were RIIs and were part of the larger stabilizer assembly, listed in the FAA-approved operator's GMM as an RII. The manufacturer noted by letter (See appendix G) that the subject assembly met the operational requirement of the FAA for a RII, in accordance with 14 CFR 135.427(b)(2).

2.4 Maintenance Factors

The evidence is clear that the events during the maintenance and inspection of N33701 the night before the accident were directly causal to the accident. Several errors were made by the individuals responsible for the airworthiness of the airplane. The Safety Board believes that the reasons for the errors and the overall failure of the maintenance program are complex and are not simply related to a single failure by any single individual. Consequently, the Safety Board's analysis of the maintenance and inspection program concentrated on the systemic reasons for the accident, as well as the specific errors made by the individuals concerned.

The Continental Express GMM had FAA-approved procedures for shift turnovers. These procedures included briefings by mechanics to supervisors, briefings by outgoing supervisors to incoming supervisors, completion of maintenance and inspection shift turnover forms (so that oncoming personnel would be aware of incomplete work), and the documentation of incomplete work that would be noted by the mechanic on the reverse sides of M-602 work cards. In fact, the Safety Board found no specific deficiencies in the GMM, other than the fact that the GMM did not delineate or identify specifically the horizontal stabilizer leading edge deice boots as an **RII**. Only the major structural items were listed. However, this deficiency alone did not cause the accident, and it is not unique to Continental Express. This issue is discussed further in section 2.5. The Safety Board concludes that the GMM contained clear procedures, which, if followed, could have prevented the accident.

The Safety Board concludes that the upper row of screws that had been removed from the leading edge of the left horizontal stabilizer was undetected because the approved procedures in the GMM were not followed by the maintenance, supervisory and quality control personnel directly charged with evaluating the airworthiness of N33701 before it was returned to service. The following are examples of substandard practices and procedures and oversights by individuals, who had an opportunity to prevent the accident:

Second Shift Supervisor Responsible for N33701

The second shift supervisor responsible for N33701 failed to solicit an end-of-shift verbal report (shift turnover) from the two mechanics he assigned to remove both horizontal stabilizer deice boots. Moreover, he failed to give a turnover to the oncoming third shift supervisor and to complete the

and practices for establishing **RIIs.** Such a review should include manufacturers and airlines in order to develop more specific requirements.

2.6 Senior Management

A major concern in this case is whether the problems noted represented aberrations related to individual maintenance personnel (there were several) or rather reflected systemic issues related to company policy. The influence of senior managers is often less tangible than that of line employees. However, the effects of management policy can be profound, and pervasive, affecting the company at all levels. For accident prevention purposes, it is important to determine at what level of the company structure--from the hangar floor to the highest executive--that attention should be focused to correct the problems that were discovered in this investigation.

The Safety Board does not believe that the maintenance issues were related solely to the actions of individual employees who were in the hangar the night before the accident. There was no indication of drug problems, unusual background, or behavioral issues related to individuals. The failure to follow proper turnover procedures--the most dramatic failure in the accident--involved mechanics, supervisors, and inspectors from two shifts and noncompliance with GMM procedures. Other problems noted include the definition of work on the horizontal stabilizer leading edge as a non-RII, and the failure to follow manufacturer-published procedures for an elevator balance and an engine overtorque event not associated with the accident. These items suggest a general disregard for following established procedures on the part of maintenance department personnel.

Two safety specialists at the Boeing Commercial Airplane Company have recently reported on a survey that examined air carrier policies and their relation to accident history.[4] A small group of operators of Boeing aircraft that displayed exceptional safety records over a lo-year period was interviewed. This survey was conducted to obtain information on safety techniques that could be brought to the attention of all operators of Boeing aircraft. They found that:

> These operators characterize safety as beginning at the top of the organization with a strong emphasis on safety and this permeates the entire operation. Flight operations and training managers

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[4]Lautman, L.G., and Gallimore, P. L., "Control of Crew-caused Accidents," *Flight Safety Digest*, Flight Safety Foundation, October 1989.

> recognize their responsibility to flight safety and are dedicated to creating and enforcing safety-oriented policies. The presence or absence of a safety organization did not alter the total involvement of these managers. However, a majority of the operators did maintain an identifiable flight safety focal point. There is an acute awareness of the factors that result in accidents, and management reviews accidents and incidents in their own airline and in other airlines and alters their policies and procedures to best guard against recurrence.... This management attitude, while somewhat difficult to describe, is a dynamic force that sets the stage for standardization and discipline in the cockpit brought about and reinforced by a training program oriented to safety issues.

Several research papers have recently examined the activities of upper management that can predispose an organization to having accidents.5 They concluded that such activities need to be addressed for meaningful accident investigation and prevention. In this accident, the Safety Board was confronted with a situation in which established company procedures were not being followed by personnel in the hangar. Inspectors, who were responsible for assuring the quality of work in accordance with established procedures, were among the worst offenders. The Safety Board concludes that if Continental Express had had an effective quality assurance program, the company would have detected the procedural deficiencies noted during this investigation. The investigation revealed that the maintenance department personnel were generally aware of the correct procedures. Consequently, the lax attitude of personnel in the hangar suggests that management did not establish an effective safety orientation for its employees. In fact, the failure of management to ensure compliance with air carrier policy must be considered a factor in the cause of the accident.

2.7 Regulatory Oversight

FAA oversight of the airline failed to fiid safety problems, such as those found during the Safety Boards investigation. This oversight included routine monitoring by a principal maintenance inspector (PMI) and a special National Aviation Safety Inspection Program (NASIP) team inspection following the accident.

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[5]Maurino, D., "Corporate Culture Imposes Significant Influence on Safety," *International Civil Aviation Organization Journal*, April 1992.

In the case of the routine inspection, the former **PMI** indicated that he was subjected to a tremendous workload that limited the effectiveness of his safety monitoring. During the time he served as PMI, from February 1989 to June 199 1, Continental Express expanded significantly. For example, it began as Britt Airways, Inc., with a fleet of about 45 airplanes, merged with Rocky Mountain Airways (1989) and acquired major assets of Bar Harbor Airways (1990). At the time of the accident, the company operated a fleet of 101 airplanes (44 Part 121 and 57 Part **135),** which the **PMI** characterized as the largest number of airplanes on a single commuter Air Carrier Certificate in the United States. The former **PMI** indicated that he reviewed and approved four different **GMMs** during this expansion period, including an 1%volume GMM used at the end of his tenure. He stated that he operated for about 1 year as the sole inspector at the airline's Houston headquarters, during which time he had additional certificate responsibilities. He was later provided an assistant (whom he trained), and his other certificate responsibilities were removed. The entry of the airline into bankruptcy protection, however, required additional surveillance, and no additional personnel were provided to assist him. He indicated that the workload considerably limited his time for on-site inspection. He stated that he could keep up with the number of required inspections but that the depth and quality of these inspections were limited by a lack of time.

The PMI, who assumed responsibilities one week before the accident, characterized his workload as "extremely full." He stated that he worked evenings and weekends to fulfill all his responsibilities. Maintenance personnel at Continental Express indicated that they saw FAA personnel in the hangar infrequently, providing estimates of "perhaps a couple times per month at maximum...once every 2 months...every 2 or 3 months...once every 3 months, and...the last visit might have been 6 or 7 months before." A supervisor on the second shift said that FAA visits were always announced with usually 1 day's notice in advance.

It is clear to the Safety Board that the **PMI's** limited visits to the hangar floor would make observations of deviations from GMM procedures difficult, forcing the **PMI** to rely exclusively on paperwork records that might not have reflected actual conditions. In this accident, the mechanics failed to provide a written indication of a turnover on the M-602 work order cards, an oversight that was a major factor in the accident sequence. However, after the work was completed and signed off, any future inspector would have missed this fact.

Shortly after the accident, a NASIP team completed an inspection of the Continental Express maintenance program. A letter of November 18, 1991, to the airline management from then FAA Administrator James B. Busey stated, "During our inspection, the team favorably noted that Britt Airways [doing business as Continental Express] has implemented an internal evaluation program. The inspection revealed very few safety deficiencies, a fact we attribute, in part, to the success of your internal evaluation system."

The Safety Board is concerned that the limited scope of the NASIP inspection might have failed to uncover areas relevant to the accident. For example, the NASIP inspection did not fiid deficiencies in shift turnover procedures. It is known that after the accident Continental Express took some action to ensure compliance with the procedures required in the GMM. However, the Safety Board believes that a thorough review of previous shift turnover records might have revealed some paperwork deficiencies. An inspection for both the completion of the proper paperwork, and following the paperwork trail for randomly selected open items, from inception to completion, as well as a hands-on inspection of aircraft and an observation of work performance and turnover procedures during all shifts, might have deepened the level of observation during the postaccident NASIP inspection.

In summary, the Safety Board concludes that FAA surveillance of Continental Express was inadequate because it failed to identify and correct deficient management actions and oversight of the airline's maintenance department, as well as to identify practices in the maintenance program that were contrary to the GMM.

As the result of information obtained during the investigation about the adequacy of maintenance practices at Continental Express, on February 28, 1992, the Safety Board issued two safety recommendations to the FAA to:

A-92-6

> Enhance flight standards surveillance of Continental Express, to include sufficient direct observation of actual maintenance shop practices, to ensure that such practices conform to the Continental Express General Maintenance Manual and applicable Federal Aviation Regulations.

3. CONCLUSIONS

3.1 Findings

1. All crewmembers and air traffic controllers were properly certified to perform their duties.

2. There was no evidence of flightcrew activities during the preflight inspection or during the accident flight that were causal to this accident.

3. There was no evidence of air traffic controller activity that was causal to this accident .

4. Weather was not a factor in the accident.

5. There was no evidence of engine or flight control malfunctions.

6. The accident was precipitated by the loss of the left horizontal stabilizer leading edge when the airplane was in a descent 12 knots below its maximum safe operating speed, within its operating envelope.

7. The airplane pitched severely nose down upon the loss of the left horizontal stabilizer leading edge, and the wings stalled negatively.

8. The violent motion of the airplane and the extreme **airloads** that resulted from the loss of the left horizontal stabilizer leading edge caused the airplane to break up in flight.

9. An in flight fire occurred during the structural breakup.

10. The left horizontal stabilizer leading edge separated from the airplane because the upper row of screw fasteners (47) was not in place. The **airloads** during the descent caused the surface to bend downward and separate.

11. The upper row of fasteners for the left horizontal stabilizer leading edge had been removed during scheduled maintenance

the night before the accident, and a breakdown in procedures failed to detect that the work was incomplete.

12. The Continental Express FAA-approved General Maintenance Manual (GMM) contained adequate procedures for maintenance and quality control.

13. There was a lack of compliance with the GMM procedures by the mechanics, inspectors, and supervisors responsible for ensuring the airworthiness of N33701 the night before the accident.

14. The lack of compliance with the GMM procedures by the Continental Express maintenance department led to the return of an unairworthy airplane to scheduled passenger service.

15. The replacement of the horizontal stabilizer deice boots, which required removal of the leading edges, should have been treated as a required inspection item (RII). This would have required the proper quality control of work performed on this critical aerodynamic surface.

16. Continental Express failed to follow established requirements for performing maintenance during repair of the right elevator and following an engine overtorque on N33701, although these oversights were not causal to the accident.

17. The deficiencies noted in the maintenance department at Continental Express indicate that the airline's management did not instill an adequate safety orientation in its maintenance personnel by emphasizing the importance of adhering to procedures.

18. The routine surveillance of the Continental Express maintenance department by the FAA was inadequate and did not detect deficiencies, such as those that led to the accident involving N33701.

19. The accident was nonsurvivable.

3.2 Probable Cause

The National Transportation Safety Board determines that the probable cause of this accident was the failure of Continental Express maintenance and inspection personnel to adhere to proper maintenance and quality assurance procedures for the airplane's horizontal stabilizer deice boots that led to the sudden in-flight loss of the partially secured left horizontal stabilizer leading edge and the immediate severe nose-down pitchover and breakup of the airplane. Contributing to the cause of the accident was the failure of the Continental Express management to ensure compliance with the approved maintenance procedures, and the failure of FAA surveillance to detect and verify compliance with approved procedures.

4. RECOMMENDATIONS

As a result of its investigation of this accident, the National Transportation Safety Board makes the following recommendations to the Federal Aviation Administration:

> In cooperation with aircraft manufacturers and airlines, conduct a review of the regulations, policies, and practices related to establishing required inspection items (RIIs) for airline maintenance departments with the view toward developing more specific identification of RIIs. (Class II, Priority Action) (A-92-79)
>
> Require that airlines operating under 14 CFR Parts 135 and 121 study the feasibility of developing a means to advise flightcrews about recent maintenance, both routine and nonroutine, on the airplanes that they are about to fly, so that they have the opportunity to be alert to discrepancies during preflight inspections and possibly to make an additional inspection of critical items, such as required inspection items (RIIs), that may affect the safety of flight. (Class II, Priority Action) (A-92-80)
>
> Also, as a result of this investigation, on February 28, 1992, the Safety Board issued two safety recommendations to the FAA to:
>
> A-92-6
>
> Enhance flight standards surveillance of Continental Express, to include sufficient direct observation of actual maintenance shop

practices, to ensure that such practices conform to the Continental Express General Maintenance Manual and applicable Federal Aviation Regulations.

A-92-7

Enhance flight standards Program Guidelines, including the National Aviation Safety Inspection Program, to emphasize hands-on inspection of equipment and procedures, unannounced spot inspections, and the observation of quality assurance and internal audit functions, in order to evaluate the effectiveness of air carrier maintenance programs related to aircraft condition, the adherence to approved and prescribed procedures, and the ability of air carriers to identify and correct problems from within.

The FAA responded to these two recommendations in a letter dated May 15, 1992. The Safety Board's response to that letter, and to other letters from the FAA about open safety recommendations on FAA surveillance of air carrier operations and maintenance practices, is attached as Appendix I.

BY THE NATIONAL TRANSPORTATION SAFETY BOARD

Susan Coughlin
Vice Chairman

John K. Lauber
Member

Christopher A. Hart
Member

John Hammerschmidt
Member

Chairman Vogt did not participate.

John K. Lauber, Member, filed the following dissenting statement:

I am perplexed by the majority decision that the actions of Continental Express senior management were not causal in this accident. The report identifies "substandard practices and procedures and oversights" by numerous individuals each of whom could have prevented the accident. Included are mechanics, quality assurance inspectors, and supervisors, all of whom demonstrated a "general lack of compliance" with the approved procedures. Departures from approved procedures included failures to solicit and give proper shift-change turnover reports, failures to use maintenance work cards as approved, failures to complete required maintenance/inspection shift turnover forms, and a breach in the integrity of the quality control function by virtue of an inspector serving as a mechanic's assistant during the early stages of the repair work performed on the accident aircraft.

Furthermore, Safety Board investigators discovered two previous maintenance actions taken on the accident aircraft, each of which departed from the approved procedures, and each of which involved employees different from those engaged in the deicing boot replacement. The first event was the replacement of an elevator without use of manufacturer-specified and required balancing tools. The second was a failure to follow specified procedures and logging requirements in response to an engine overtorque. Although these events were in no way related to the accident, the report indicates that they "suggest a lack of attention to established requirements for performing maintenance and quality control in-accordance with the GMM." That these were the only other instances noted in this investigation cannot be taken to mean that these were the only such instances extant--the Safety Board's investigation of maintenance records was curtailed, as I understand it, to accommodate the needs of the FAA's NASIP team, and thus, this record is not complete.

Another factor to be considered here was the failure of Continental Express maintenance and quality assurance personnel to treat the deicing boot replacement, which requires removal of the leading edge of the horizontal stabilizer, as a Required Inspection Item (RII). By doing so, a separate inspection by quality control inspectors would have been required of the work performed that night. Even though regulations clearly establish that the horizontal stabilizer is an RII, Continental Express maintains that the deicer boot/leading edge assembly was a "non-structural" item, and therefore not subject to the more rigorous inspection requirements. I find it very disturbing that senior personnel responsible for aircraft maintenance apparently do not understand that the leading edge of any airfoil is a critical determinant of the aerodynamic characteristics of that airfoil, and thus that improper repair work could seriously compromise the safety of an aircraft.

Still another factor that I believe to be highly relevant here was the absence of a Lead Mechanic and a Lead Inspector as specified in the GMM. Senior management's failure to fill these positions in effect diffused and diluted the chain of authority and accountability among maintenance and inspection personnel at Continental Express. A detailed examination of the organizational aspects of the maintenance activities the night before the accident reveals a melange of crossed lines of supervision, communications and control. This situation, more than any other single factor, was directly causal to this accident.

The multitude of lapses and failures committed by many employees of Continental Express discovered in this investigation is not consistent with the notion that the accident resulted from isolated, as opposed to systemic, factors. It is clear based on this record alone, that the series of failures which led directly to the accident were not the result of an aberration, but rather resulted from the normal, accepted way of doing business at Continental Express. The conclusions in our report note the "failure of management to ensure compliance with air carrier policy" and its failure to "establish an effective safety orientation for its employees." Line management of an airline has the regulatory responsibility for not only providing an adequate maintenance plan (and we conclude that the GMM was, in most respects, an adequate plan) but for implementing the provisions of that plan as well. By permitting, whether implicitly or explicitly, such deviations to occur on a continuing basis, senior management created a work environment in which a string of failures, such as occurred the night before the accident, became probable. Accordingly, their role must be considered causal in this accident.

Finally, I note for the record my concerns about the way certain factual background information regarding senior management personnel has been handled in this report. As discussed in our Board meeting, but not in the report, two senior managers at Continental Express previously held positions of key responsibility at two other airlines, one airline of which was the subject of both civil and criminal litigation for maintenance-related practices, and the other airline of which experienced a major accident which this Board determined to be, in part, due to failures and deficiencies in that airline's maintenance program and in the management thereof. Both people were in line management positions within their maintenance organizations during the time of the deficient practices, all of which involved deviation of actual practices from those specified in relevant, official, and approved documents. I am in no better position than anyone else to determine how directly relevant to the present accident this information is. e i t i s factual information of the kind we routinely collect in any accident investigation, and is already in the public record, and since it is clearly not inconsistent with the

management practices noted in this investigation, I believe it is relevant to this discussion, and thus deserves explicit mention here. To do otherwise is to make a de facto decision that this information is clearly **not** relevant, a decision which I am unwilling to support.

I believe the probable cause should read as follows:

The National Transportation Safety Board determines that the probable causes of this accident were (1) the failure of Continental Express management to establish a corporate culture which encouraged and enforced adherence to approved maintenance and quality assurance procedures, and (2) the consequent string of failures by Continental Express maintenance and inspection personnel to follow approved procedures for the replacement of the horizontal stabilizer deice boots. Contributing to the accident was the inadequate surveillance by the FAA of the Continental Express maintenance and quality assurance programs.

John K. Lauber
Member

July 21, 1992

15

Michael McCafferty/AWA/FAA

AFS-006, Special Assistant to the Director

07/08/2008 10:41 AM

To Mark Lund/AGL/FAA@FAA, "Linda Goodrich" <LGOODRICH@passnational.org>, David E Hanley/AGL/FAA@FAA

cc Nick Sabatini/AWA/FAA@FAA, Peggy Gilligan/AWA/FAA@FAA, Jim Ballough/AWA/FAA@FAA, John Allen/AWA/FAA@FAA,

bcc

Subject Fw: Whistleblower Retaliation & SIRS Item "Next Steps"

Good morning, Mark!

Sorry for not sending you this email until today, but I was out last Thursday extending the July 4th holiday weekend (taking my family to Pennsylvania to visit relatives) and yesterday was "catch up" day.

Why am I writing?

Well, as you know, it's been a couple years since I visited your office and I've recently changed jobs. As of February, I'm the Executive Officer for AFS headquarters. Of the many programs we have, my staff and I serve as the AFS initial intake for all SIRS items that are filed at the national level. As such, we'll be tracking as well as, hopefully, facilitating timely response to your safety concerns. In this regard, I had a very brief telephone conversation with Linda yesterday so she's aware of this matter and I've been contacted by AGL-200 staff, too. That's why I've included Linda and Dave as recipients of this message.

At this point, the norm is for me (and my staff) to work with the regional division manager's staff to first discern all of the safety issues and then to determine the appropriate response. We're allowed 20 days to do this work; more if really needed. Hopefully, we'll have the response to you sooner. Just so you know, for the other 10-12 SIRS items that were filed nationally, we've had Jim Ballough sign the reply. I'll send you the reply to your SIRS item before it's posted in the SIRS sharepoint site so you may provide your feedback to ensure we've addressed the safety concerns. Our goal is that you'll concur with the response.

In closing, we view this as an opportunity to examine the safety concerns collaboratively. And, as we highly value your feedback about how you, personally, believe the SIRS process deals effectively with your safety concerns, we'll be seeking your active involvement in helping us ensure we understand and act upon the safety concerns you've raised. Moreover, as Nick reaffirmed, there will be no reprisal or retaliation!

I'll keep you informed as these matters progress. Please feel free to contact me be email or telephone, too.

Regards,

Mike
202-267-3928

----- Forwarded by Michael McCafferty/AWA/FAA on 07/08/2008 10:52 AM -----

Nick Sabatini/AWA/FAA
AVS-001, Offc. of the Associate Administrator

07/03/2008 07:28 AM

To Mark Lund/AGL/FAA@FAA

cc 9-AWA-AVS-SIRS, Jim Ballough/AWA/FAA@FAA, John Allen/AWA/FAA@FAA, Michael McCafferty/AWA/FAA@FAA, Peggy Gilligan/AWA/FAA@FAA

Subject Re: Fw: Whistleblower Retaliation

Mark

Thank you for bringing this matter to my attention . For purposes of assuring timely follow-up and tracking, I have submitted this issue into SIRS. Please rest assured that I will pay close personal attention to the review of the issue. As I have publicly stated. I will not tolerate reprisal or retaliation in any way , shape or manner. You have my utmost respect as a safety professional and I fully expect that you will be treated accordingly. Because of the long holiday weekend you can expect to be contacted early next week. Once again. Thank you for bringing this to my attention first and the opportunity for timely resolution.

Nick
Mark Lund/AGL/FAA

Mark Lund/AGL/FAA
AGL-MSP-NWA-CMO-01,
Minneapolis, MN

07/02/2008 03:58 PM

To Nick Sabatini/AWA/FAA@FAA
cc
Subject Fw: Whistleblower Retaliation

Mr. Nick Sabatini:

With due respect for your position as FAA Director of Aviation Safety, I am forwarding my email of safety concerns still existing at Northwest Airlines and whistleblower retaliatory acts against me for your due consideration and actions. I am hopeful that your are a man of your word as you have stated in the media and Congressional Hearings that you will not accept whistleblower retaliation against inspectors for doing their jobs to protect public safety and bringing forth safety concerns.

As you can see by the email traffic below, I submitted this through my FAA chain of command. Mr. David Hanley, Great Lakes Regional FS Director, recommended I forward my email directly to you. My email message to you follows the forwarding history.

I am hopeful that you will take direct action to resolve.

Respectfully,

Mark S. Lund
FAA Safety Inspector
FAA Northwest Airlines Certificate Management Office
952-814-4316

----- Forwarded by Mark Lund/AGL/FAA on 07/02/2008 02:29 PM -----

David E Hanley/AGL/FAA
AGL-200, Flight Standards
Division

07/02/2008 02:08 PM

To Mark Lund/AGL/FAA@FAA
cc Ken McGurty/AGL/FAA@FAATho, Sam Varajon/AGL/FAA@FAA, Thomas Winston/AGL/FAA@FAA
Subject Re: Fw: Whistleblower Retaliation

Hi Mark,

Notwithstanding any previous direction you have been given to follow the chain of command for communications, you are free to directly communicate any concerns you have about retaliation to anybody inside or outside of the FAA. While I do not feel that the recent issuance of non-conformance records (NCR) to Great Lakes Region field offices to ensure adherence to existing FAA enforcement policy, or a reminder by your supervisor of the chain of command communication expectations established at the 3/09/2006 meeting (that included yourself, your supervisor, the PASS union, and regional and headquarters officials) are retaliatory in nature, I do not want to stand in the middle of your elevation of any concerns you have that you perceive to be retaliatory. Therefore, while I will not be forwarding your e-mail to Mr. Sabatini as you requested, you should feel free to do so yourself. Thanks.

Dave

Ken McGurty/AGL/FAA

Ken McGurty/AGL/FAA
AGL-MSP-NWA-CMO-01,
Minneapolis, MN

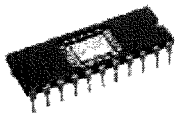
07/02/2008 10:53 AM

To David E Hanley/AGL/FAA@FAA
cc Thomas Winston/AGL/FAA@FAA, Roy Peterson/AGL/FAA@FAA, Mark Lund/AGL/FAA@FAA
Subject Fw: Whistleblower Retaliation

Dave, below is an Email from Mark Lund. He is requesting this Email be forward to Mr. Sabatini. In the body of the Email he states he did not want to use the new SIRS process. He did state that this Email is to be regarded as a "Whistleblower" complaint.

Ken McGurty
NWA CMO MANAGER
952-814-4327

Your feedback is appreciated:
http://www.faa.gov/about/office_org/headquarters_offices/avs/offices/afs/qms/
----- Forwarded by Ken McGurty/AGL/FAA on 07/02/2008 10:43 AM -----



Sam Varajon/AGL/FAA
AGL-MSP-NWA-CMO-01,
Minneapolis, MN

07/02/2008 10:09 AM

To Ken.McGurty@faa.gov
cc
Subject Fw: Whistleblower Retaliation

Sam Varajon
NWA/CMO/SPAI
Ph. #952-814-4326
FAX. #952-814-4329

Your feedback is appreciated:
http://www.faa.gov/about/office_org/headquarters_offices/avs/offices/afs/qms

----- Forwarded by Sam Varajon/AGL/FAA on 07/02/2008 10:08 AM -----

Mark Lund/AGL/FAA

AGL-MSP-NWA-CMO-01, Minneapolis, MN

To Sam Varajon/AGL/FAA@FAA

cc

07/01/2008 05:27 PM

Subject Whistleblower Retaliation

Please respond to
Mark Lund by 07/01/2008

Mr. Sam Varajon
Supervisory Principal Avionics Inspector
FAA Northwest Airlines Certificate Management Office

Mr. Varajon:

Please forward this email through the proper FAA management chain of command to Mr. Nick Sabatini, FAA AVS-1, FAA Director of Aviation Safety

I am requesting a receipt acknowledgement at each level of management for my records that this email message has been forwarded and has been read by Mr. Sabatini.

Since this is being forwarded through electronic email which travels very fast, I would expect a read receipt from Mr. Sabatini by July 8, allowing for the upcoming holiday weekend.

Thank you for your prompt attention to my request and my efforts to follow FAA chain of command.

Mr. Sabatini:

I am sending you this email for your direct attention and involvement to stop whistleblower retaliatory acts by the Great Lakes Regional Management, one being Mr. Todd Pearson, under the Great Lakes Regional Flight Standards Division Manager, Mr. David Hanley.

I believe I am being targeted by the Great Lakes Regional managers for my identification of public safety risks at Northwest Airlines due to my Airworthy Directive findings of non-compliance and the substantial civil penalty enforcement investigations I am in work on (8 presently with one currently in the Region which calculates to $5.4M.)

I am personally advising you that my next chain of command level that I will take if this harassment and planned retaliatory acts against me by FAA Management does not stop is the US Office of Special Counsel, the Department of Transportation IG and the Honorable Senator from my home state of Minnesota, Mr. Jim Oberstar, all of whom you are familiar with. I do have a credible standing with the IG

and have been on first name basis with some of their investigators.

You have spoken out publicly that you and the FAA Administrator will not tolerate retaliatory acts against inspectors for speaking up with their safety concerns. I will tell you directly, Northwest Airlines continues to be an airline at risk to public safety and since September 2007's release of the IG report, continues to be a public safety risk and it is clearly demonstrated in the past years FAA enforcement investigations for improper maintenance and the un-safe operations with those aircraft.

Did you know that a Northwest Airlines DC9 had an elevator power control actuator rod separate from its attach point causing the nose to lift off 15-20 kts prior to lift off V1 speed and the flight crew had difficulty controlling the elevator after lift off. They were able to get the passenger flight back to the airport. Cause, Improper maintenance, a cotter key was not installed in the castellated nut. The nut and washer were found in the elevator area. This is basic aircraft maintenance procedure, to install cotter keys in castellated nuts on primary flight controls...EIR # 2008GL010152, DC9, N600TR, About April 15, 2008. Caused by a contract vendor...

Today, July 1, 2008, I was warned by supervisor Sam Varajon, to follow FAA chain of command as I had contacted a Ms, Maria Acevedo in the Great Lakes Region, when at the time, I was unaware she was a manager. According to an email that was forwarded to me by my supervisor Varajon, her name did not include "Manager" and I assumed her to be a Regional specialist reviewing my submitted EIR # 2008GL010079, for improper maintenance which caused repetitive un-commanded rudder movements during take off and landing approach on a Passenger B757 which holds 184 seats.

Well, there are 2 recent unsafe public risk examples on Northwest Airlines. The EIR 2008GL010079 contains specific references to other EIRs since the fall of 2007 for improper maintenance and the resulted un-safe operation by Northwest Airlines of the aircraft.

As you are directly aware, the coziness of the FAA to the airline has also been under scrutiny. I must bring your attention to the appearance of coziness with Northwest Airlines and the Great Lakes Region. FAA Administrative managers have experienced their short falls at the Regional and Washington levels at Southwest Airlines, ValuJet (accident killed people) Alaska Airlines (accident killed people), Northwest Airlines (is at risk for an accident to kill people). In all cases of these 4 airlines, FAA Flight Standards safety inspectors raised their public safety concerns to FAA Administrative levels of management. It has only been outside the FAA where their concerns were verified and external pressure applied to FAA management to gain correction to ensure public safety.

I am offering you an opportunity to demonstrate to me your honest firm actions to stop the retaliatory acts against me and to ensure public safety of Northwest Airlines. I have not used the "New" FAA safety reporting process as the process is very similar as to what I attempted to use in the submission of my safety recommendation in 2005. FAA did nothing but spent their efforts to fault me, of which I received Letters of Reprimand, during the time of my safety recommendation and the release of the IG report. Does FAA truly learn from anything that happens?

I am choosing to send you a personal email of my concerns and my situation in the hopes that you will apply your personal attention and stand by your word while demonstrating personal integrity as the FAA Director of Aviation Safety...To standby what you have said in the Congressional Hearings and media.

I have tremendous access to the media as well but I have, as in the past chosen to work with the FAA, my employer, as I too believe collaborative working together is my preferred way and potentially the best way for all parties..To look at improving public safety instead of expending resources to set-up and discipline FAA inspectors for just trying to do their job keeping the public safe despite how "unfriendly" it appears to the airline.

The indications are that Mr. Todd Pearson, Great Lakes Region was the one that requested Mr. Varajon to warn me to follow FAA chain of command.

This is significant to me and my case as I was previously set up and reprimanded for not following an FAA chain of command when I attempted to get a copy of my Performance Review which is suppose to be given to me anyway. This occurred after my submitted Safety Recommendations for un-safe maintenance practices at Northwest Airlines following their mechanics strike and I was removed from my duties because of a frivolous claim against me by Northwest Airlines. The IG report of September 2007 supports my safety concerns and I am sure you are fully aware of.

Yet, I was and am presently being targeted by the Great Lakes Regional Management as I suspect now are related to my large, substantial enforcement cases and my findings of AD non-compliance at Northwest Airlines during the FAA directed AD inspection under FAA Order 8900.36. Northwest Airlines did operate aircraft that did not have full AD compliance performed. My AD findings have all been saved into the ATOS Repository.

Both Mr. Todd Pearson and Mike McCaferty (FAA Headquarters) were in a meeting back in 2006, in which I was promised a copy of my Performance Review as is to be given to me anyway, which I never received even when I requested it multiple times from my supervisor Sam Varajon. I than made the request to Todd Pearson and Mike McCaferty, who were the other management representatives in the meeting.

By doing so, I was set up and reprimanded for stepping outside the chain of command. Once FAA management had me set up and reprimanded, I received copies of my Performance Review.

Today, July 1, 2008, I was warned by my immediate supervisory Mr. Sam Varajon, to stay within FAA chain of command with communications as I had made contact by telephone and email to a Ms. Maria Acevedo, Great Lakes Region. Her name was provided to me on an email I received from my supervisor Sam Varajon in regards to a Non-Conformance Report for EIR 2008GL010079 that I wrote in which a recommended sanction amount was in the Section B narrative for $5.4M. The NCR wanted the amount removed from page 35 of the EIR as non-conformance with FAA Order 2150.3B.

As I understand the FAA Quality Management process, The NCR number 4359, is to be routed to the person to affect resolution which would be me.

However, my supervisor, Mr. Sam Varajon, did not electronically forward the NCR to me because, as he states to me, he is not familiar with the process and he is unable to gain access to the NCR because his password access does not work.

If my Supervisor Mr. Varajon was to have followed the Quality Management process and had forwarded me the NCR, I would have than learned that Mr Maria Acevedo is a manager in the Great Lakes Region. Mr. Varajon did not share the complete NCR record with me or copy the paper copy he had. It was my impression, he was unwilling to share the whole NCR document with me.

As such, Ms Maria Acevedo was the only Regional contact I had and no where on the email I received from Varajon did it state Ms Acevedo was a Manager. At the time of my contact to her, I was unaware of her official position as an FAA manager and assumed her to be a regional specialist.

I than today, July 1, 2008 received an email from Ms Acevedo directing me to my supervisor in regards to my request for her to contact me to discuss the NCR. On her email she copied Todd Pearson.

I was than warned to follow chain of command.

Because of the lack of information provided by my supervisor and guidance for the NCR, and his position being, "We just do what the Region tells us to do" as he stated to me, I did visit with our QMS person and he pulled up the NCR, at which I did not even know the number, and he gave me the Regional specialists name and phone number so I could speak with him to assure complete resolution. I than was able to contact the Regional specialist, Mr. Randy Jones, we agreed to resolution and I made the revisions to EIR Section B.

My supervisor Varajon has already forwarded the EIR Section B revision to the Region, Randy Jones. Yet, my supervisor is unable to comply with the NCR process and get that closed out because he is locked out and unsure of the full process.

I did my job the best I could despite my immediate supervisor's deficiencies. Yet, I receive a disciplinary verbal warning to follow chain of command...

Who is going to reprimand my supervisor now for him not knowing how to follow the FAA Quality Management Process for a Non-Conformance Report (NCR)?

Mr. Sabatini, thank you for your prompt attention to this email. I am hopeful you will demonstrate to be a man of your word and of public safety integrity.

Respectfully,

Mark S. Lund
FAA Safety Inspector
FAA Northwest Airlines Certificate Management Office
952-814-4316

Michael McCafferty/AWA/FAA
AFS-006, Special Assistant to the Director

09/03/2008 03:53 PM

To Mark Lund/AGL/FAA@FAA
cc
bcc
Subject Re: Second email EIR 2008GL010079

History: This message has been replied to.

Thanks, Mark, and I'll have an ASI (maybe more) look at the information you sent me and then get back to you.

Mark Lund/AGL/FAA

Mark Lund/AGL/FAA
AGL-MSP-NWA-CMO-01, Minneapolis, MN

09/03/2008 03:28 PM

To Michael McCafferty/AWA/FAA@FAA
cc
Subject Second email EIR 2008GL010079

Mr. McCafferty:

Please find the initial EIR that you had called the Great Lakes Region on some time ago. This was the first one I submitted under the revised FAA Order 2150.3B and it was initially rejected because I had a sanction amount in the narrative and not in the 2150 form. As we talked today, the form has specific prohibited language in the 2150.3B wereas the narrative does not. The Great Lakes Region has determined that no dollar amounts should be in the narrative. However, there is no specific 2150.3B guidance that prohibits the narrative to include for reference statements quoted from the guidance, dollar amounts. This is an issue of argument within the office and by other inspectors as well as reference to FAA guidance is permissible in the narrative.

Anyway, these will take some reading and I am anticipating you will get back to me.

[attachment "2008GL010079SecBrv1pt.doc" deleted by Michael McCafferty/AWA/FAA]

As I stated to you on the telephone this morning, the issue for me is the systemic non-complinace by Northwest Airlines and their ability or desire to ensure maintenance is properly done, iaw their procedures and aircraft operated are safe and airworthy for passenger safety.

Since my 2005 Safety Recommendation, the safety risk Northwest Airlines presents to the public still exists. As I told the Special DOT "Blue Ribbon Panel" that was here interviewing us, Northwest Airlines is operating at a risk to public safety. I provided them a few examples of their safety risk that are listed in the violation history of my EIR reports...And now I am informing you of my safety concern as follow up to my initial Email to Mr. Sabatini.

Respectfully,

Mark Lund
FAA Safety Inspector