

## EXECUTIVE SUMMARY OF THRASH'S TESTIMONY

A Continental Airlines, Inc. (CALA) contract mechanic was killed during ground operations of a Continental Airlines B737 on January 16, 2006 at El Paso, Texas. This was a fatal aircraft accident and the flight crew's actions were accepted into the FAA's ASAP program during the week following the accident.

As the FAA's B-737 Aircrew Program Manager (APM) in the Continental Airlines Certificate Management Office (COA CMO) I sent a February 14, 2006 e-mail of my professional disagreement with the ASAP's decision to FAA Administrator Blakey.

On February 27, 2006 I was interviewed by the Assistant Manager of the FAA's American Airlines CMO, Mr. Don Klos, regarding my e-mail concerns at the request of Mr. Thomas Stuckey who is the FAA's Southwest Regional Division Manager of Flight Standards, ASW-200. During the interview, Mr. Klos stated that the previous week he had visited Thomas Stuckey, ASW-200, who indicated that the FAA Administrator Blakey and FAA's Associate Administrator for Safety, AVS-1, Mr. Sabatini, had told Mr. Stuckey to investigate "how the El Paso matter had been accepted into ASAP." Mr. Klos stated during the February 27, 2006 interview that he and Thomas Stuckey agreed that the accident should not have been accepted into ASAP, but that "Washington FAA" would have the final call. I advised Mr. Klos that the COA CMO Manager, Bernie Mullins and POI, John Merrifield, had stated in previous meetings with me that ASAP had not provided any precursors to the El Paso accident.

A December 17, 2001 memo written by AFS-1, FAA Director of Flight Standards Service, Mr. Ballough, gives the FAA ASAP Event Review Committee member autonomy in his/her decision to accept or reject a crewmember's ASAP report. The COA CMO's FAA's ASAP representative from 2001 until early summer of 2006 was a retired Continental Airlines Captain who was not type rated on any of Continental Airlines fleet of all Boeing manufactured aircraft. After the El Paso accident, another CALA B737 safety related incident occurred which was accepted into ASAP. The COA Manager then removed the ASAP representative from the ASAP ERC. During this FAA ASAP representative's tenure, 2001 to 2006, I was never contacted regarding any ASAP reports. The Manager, POI, and APMs could not access the ASAP data repository to gather risk indicators, accident precursors, on which to focus our limited inspector resources. From summer 2006 until my retirement, I conducted two Enforcement Investigative Reports regarding FAR violations, and four reexaminations of airmen under 47 USC 44709, which was after the former ASAP representative, the ex Continental Airline's captain, was removed from his FAA ASAP ERC position, and replaced with a FAA Aviation Safety Inspector who was rated on the Boeing B-737.

AFS-2, FAA Deputy Director of Flight Standards Service, John Allen wrote a FAA Memo dated April 28, 2006 to Administrator Blakey as FAA's Flight Standards Service official position to my February 14, 2006 e-mail. Allen's memo appears to obfuscate the facts that happened at El Paso to "cover up" those facts to support FAA's highest level of management in the FAA's Flight Standards Service, AFS-1's, and AFS-2's, decisions to sustain the El Paso matter acceptance into ASAP. The memo has fictionalizations, false statements, innuendoes, and

unfounded conclusions. I welcome your questions to me in that regard. If Mr. Allen's official memo of record was an intentional obfuscation of the facts, he maybe in violation of Federal Laws. If Mr. Allen's official record contains unintentional mistakes and misstatements of facts, he might be seen as incompetent.

On September 21, 2006, Mr. Ballough, AFS-1 sent an official FAA letter of response to the Honorable Texas Senators Hutchison and Cornyn to close their Congressional inquiries into the El Paso ASAP matter. He included Allen's aforementioned memo to corroborate FAA Flight Standards' official position on the acceptance of the El Paso ASAP matter. If Ballough intentionally forwarded to United States Senators known fictionalizations, false statements, inaccuracies, and obfuscations of facts, he may have violated some federal laws, if unintentional, his competency may be in question.

I was unable to accomplish my duties as Aircrew Program Manager to inspect, investigate this aircrew's actions due to policies and decisions made by James Ballough, AFS-1, FAA Director of Flight Standards Service and James Allen, AFS-2, FAA Deputy Director of Flight Standards Service. They sustained the acceptance of the fatal accident into the FAA's Voluntary Disclosure Program known as ASAP, Aviation Safety Action Program.

The DOT OIG has had my files since October 17, 2006, with my position that AFS-1, Ballough, and AFS-2, Allen, abused power by sustaining the acceptance of the El Paso fatal aircraft accident into ASAP. Twice, I made my self available to discuss the matter with the FAA Administrator, Blakey, AVS-1, Sabatini, AFS-1, Ballough, and AFS-2, Allen which did not happen.

FAA Associate Administrator for Safety, AVS-1, Mr. Nicholas A. Sabatini signed FAA Regulation 14 CFR Part 193, under provisions of 49 USC 40123, to essentially prohibit the release of ASAP, and other certain FAA accepted "voluntary disclosure" aviation safety information on January 26, 2005.

This regulation essentially protects ASAP, a non-regulatory, voluntary program created by a FAA Advisory Circular, from the public's right and freedom for information regarding their safety.



U.S. Department  
of Transportation  
Federal Aviation  
Administration

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JAN 7 - 2002

Southwest Region  
Flight Standards Division

# Memorandum

Subject ACTION: Aviation Safety Action Program (ASAP)

Date DEC 17 2001

From Director, Flight Standards Service, AFS-1

Reply to  
Attn. of:

200	
201A	
201B	<i>[Handwritten mark]</i>
202	
210	
230	

To: All Certificate Holding District Offices

I would like each office manager to know that I am deeply committed to the success of the Aviation Safety Action Program (ASAP), and I would appreciate the continued support of our certificate holding district offices (CHDO) for this important safety program. I believe that ASAP not only provides the Federal Aviation Administration (FAA) and airline management with otherwise unavailable information concerning flight operations and aircraft maintenance events, the program enables corrective action to be taken in those areas that would otherwise never occur. ASAP is, therefore, an invaluable supplement to our surveillance and enforcement tools for the enhancement of public safety.

With nearly 20 programs in place to date, participation in ASAP continues to grow steadily. As the FAA and industry gain experience with the program, it can be expected that FAA ASAP policy will be refined to reflect lessons learned. An advisory group comprised of airline, labor, and FAA representatives has been established by the Administrator to help us determine if policy changes for ASAP are needed. A Flight Standards Service Web page is now in place to provide the most current information on ASAP policy, pending publication of a handbook chapter on ASAP, and a revision to the current ASAP advisory circular (AC 120-66A). If changes are made to ASAP policy, they should be expected to appear first on the ASAP Web page prior to publication elsewhere. The Web page also contains an automated template to facilitate the generation of an ASAP Memorandum of Understanding (MOU) by airlines and repair stations interested in starting new programs. We strongly encourage the use of the automated template, because MOUs that use the standard language from that program can be quickly accepted. The template will always reflect the most current FAA policy on ASAP.

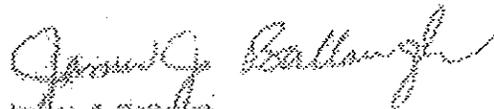
I would like to call your attention to the concept of Event Review Committee (ERC) consensus that appears in paragraph 5B(2) of the Handbook Bulletin for Air Transportation (HBAT) 00-08/ Handbook for Airworthiness (HBAW) 00-07, Establishment of Aviation Safety Action Programs. It states:

The success of ASAP is built on the ability of the ERC to achieve consensus on each event that is reported. Under ASAP, the term "consensus" is defined as the voluntary agreement of all ERC representatives. The ERC must reach a

consensus when deciding on corrective action recommendations arising from the event, including any FAA enforcement action. It does not require that all members believe that a particular decision or recommendation is the most desirable solution, but that the result falls within each member's range of acceptable solutions for that event in the best interest of safety.

In order for this concept to work effectively, the FAA member must be empowered to call it as he/she sees it within the context of the ERC discussions on a given report. Office managers should ordinarily not preempt the FAA ERC representative's decisionmaking discretion for an event reported under ASAP. If the parties to an ASAP MOU do not permit their respective ERC representatives to exercise this discretion, the capacity of the ERC to achieve consensus will be undermined, and the program will ultimately fail.

Only inspectors who have received formal training on ASAP should be selected to be the FAA representative to an ERC. I strongly encourage CHDO managers to attend this training as well.

  
Joseph J. Ballew

# Federal Aviation Regulation

Sec. 121.563

Part 121 OPERATING REQUIREMENTS: DOMESTIC, FLAG, AND SUPPLEMENTAL OPERATIONS

Subpart T--Flight Operations

Sec. 121.563

Reporting mechanical irregularities.

The pilot in command shall ensure that all mechanical irregularities occurring during flight time are entered in the maintenance log of the airplane at the end of that flight time. Before each flight the pilot in command shall ascertain the status of each irregularity entered in the log at the end of the preceding flight.

Amdt. 121-179, Eff. 10/1/82

► **Comments**

▼ **Document History**

Notice of Proposed Rulemaking Actions:

Final Rule Actions:



Joseph P Thrash/ASW/FAA  
06/07/2006 08:44 AM

To Joseph P Thrash/ASW/FAA@FAA  
cc  
bcc

Subject Fw: Administrator's Hotline Notification: CALA1515, El Paso, TX. Death of Contract Mechanic. Official Record of Professional Disagreement of Opinion of FAA's Acceptance of Pilot Crewmember's Disclosure and Acceptance of Disclosure into ASAP Program by Joseph Phil Thrash, COA CMO FAA B737 Aircrew Program Manager.

History:  This message has been forwarded.

----- Forwarded by Joseph P Thrash/ASW/FAA on 06/07/2006 08:43 AM -----

Joseph P Thrash/ASW/FAA  
02/14/2006 10:44 AM

To Marion Blakey/AWA/FAA

cc Jim Ballough/AWA/FAA@FAA, Thomas Stuckey/ASW/FAA@FAA, Bernard Mullins/ASW/FAA@FAA, John T Merrifield/ASW/FAA@FAA, Daniel S McLucas/ASW/FAA@FAA, James R Clark/ASW/FAA@FAA  
Subject Administrator's Hotline Notification: CALA1515, El Paso, TX. Death of Contract Mechanic. Official Record of Professional Disagreement of Opinion of FAA's Acceptance of Pilot Crewmember's Disclosure and Acceptance of Disclosure into ASAP Program by Joseph Phil Thrash, COA CMO FAA B737 Aircrew Program Manager.



Administrator's Hotline  
AOA-20 Room 1003  
800 Independence Avenue Southwest  
Washington, D.C. 20591

Administrator Blakey:

Please make this E-mail notification the preliminary official record of my professional disagreement of this event being accepted into the Aviation Action Safety Program. I will provide an official FAA Letter and/or memo for the official permanent file records with specific details of my concerns and reasons for my professional disagreement of this matter.

A few days after the El Paso event I was taken off routine surveillance and certification duties to prepare interview questions at request of COA Principal Operations Inspector; John T. Merrifield, and COA Certificate Manager; Bernard Mullins. I prepared the questions which were reviewed and accepted by the POI and Manager on or about January 19, 2006. My attempt to interview the crew on January 20, 2006 was thwarted by Continental Airlines, Inc. as the crew was going through an Employee Assistance Program. I was dispatched by local management to attend a previously scheduled out of agency training during week of January 23, 2006 through January 27, 2006.

On January 19, 2006, at CMO Manager's request the interview questions were provided to the ASAP Event Review Committee (ERC) FAA members Jim Dixon, and Paul LeBlanc. Subsequently, I learned that the questions were never put to the pilot crewmembers involved in the accident. Upon my return from the out of agency training, I also learned that the Event Review Committee, made up of three persons, one FAA, one CALA company person, and a CALA Union Representative, had accepted the crew's ASAP report into the ASAP program for remedy.





I am attaching the questions I developed which were not asked of the crew by the ASAP FAA personnel. Pictures of the aftermath of the El Paso accident are included.

A letter and/or Memo will follow with more detailed concerns as official permanent records. A digest of my preliminary concerns for your perusal in this E-mail follow:

1. The pilot crewmembers were not following any FAA approved procedures in their FAA approved Flight Operations Flight Manual, Checklists or Minimum Equipment lists.
2. The pilot crewmembers were accomplishing a high power engine run-up for which they had received no FAA Approved training .
3. The L-1 Forward Door was open with a galley service truck unloading a wheelchair passenger, which is contrary to CALA's Before Start Checklist, where all doors are checked closed with door warning lights out. This was being done during the high power engine run up.
4. The pilots did not get ATC approval to accomplish the high power run up.
5. The pilots did not make a maintenance log book entry for the mechanic to review.
6. The pilots did not contact their CALA Maintenance Control with nature of discrepancy and to get Maintenance recommendations for maintenance procedure to follow.

I submit as a minimum the FAA Should have:

1. Done an emergency Pilot certificate revocation on both pilots.
2. Not accepted the event into the ASAP program due to the pilots' intentional egregious careless and reckless operation of the aircraft at high power settings.
3. Issued LOIs to both pilots for alleged violations of FAR concerning careless and reckless operation.
4. Issued Letters to both pilots for Reexamination of Competency under Provision 44709 of The FAA Act Of 1958 as recodified.



I personally feel that FAA can be severely criticized by outside agencies, NTSB, OSHA, and Legal Entities looking at possible wrongful death causes in this accident.

I personally feel that by accepting this event into ASAP, FAA may be viewed as culpable of an obstruction of justice for failure to investigate the accident under provisions of the aforementioned FAR dealing with "careless and reckless" operation.

I am available to discuss these matters with anyone of you or all of you.

This is my preliminary personal professional disagreement with the decision that this matter was accepted into the ASAP program.

Phil Thrash  
FAA B737 Aircrew Program Manager  
Continental Airlines CMO  
Houston, TX 77058  
281-461-2448  
E-mail Joseph.P.Thrash@faa.gov



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CALA1515IMG\_0056.JPG



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# Federal Aviation Administration

Enclosure 2 p. 1.

J.P. Thrash

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## Memorandum

Date: APR 18 1981

To: Manager, Hotline Operations Program, AOA-20

From: John M. Allen, Deputy Director, Flight Standards Service, AFS-2 <sup>CSJ</sup> <sub>fa</sub>

Prepared by: Wanda Moore, AFS-10

Subject: Administrator's Hotline Information System Request #200602150001

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In response to the subject hotline complaint, Flight Standards conducted an inquiry. The complaint, submitted by Mr. Joseph P. Thrash, concerns the actions taken by the Federal Aviation Administration (FAA) in response to a ground accident involving a Continental Airlines (CALA) aircraft in El Paso, Texas. Mr. Thrash is currently assigned as an assistant partial program manager at the Continental Airlines Certificate Management Office (COA CMO) in Houston, Texas.

On January 16, at El Paso International Airport (ELP), during the dispatch preparations of CALA Flight 1515, the flightcrew noticed a fluid leak under the number two engine during a walk around inspection. The crew requested that maintenance personnel investigate the possible leak. Two maintenance mechanics positioned themselves by the engine to troubleshoot the reported leak during engine run-up. The flightcrew operated the number two engine at 70 to 75 percent power, when one of the mechanics, Mr. Donald Buchanan, was ingested into the engine and killed. This accident is currently under investigation by the FAA and the National Transportation Safety Board (NTSB).

In his complaint, Mr. Thrash provided a list of concerns regarding this accident that are addressed below:

**Concern 1:** The pilot crewmembers were not following any FAA-approved procedures in their FAA-approved Flight Operations Manual, Checklists, or Minimum Equipment Lists.

**Response:** The investigation into this accident has shown that the crew did not have guidance for a maintenance engine run at the gate, and instead appeared to rely on the verbal instructions given by the mechanic. This was found to be a deficiency. CALA will take corrective action based on the results of the Systems Analysis Team (SAT) review organized by the COA CMO. The projected completion date of this review is May 2.

**Concern 2:** The pilot crewmembers were accomplishing a high power engine run-up for which they had received no FAA-approved training.

**Response:** This is a true statement. Prior to this accident, there was no training or published guidance in the pilot's manuals for engine maintenance runs. This is being included as part of the SAT review. As an interim measure, the carrier has provided guidance to personnel at CALA requiring certain checklist items to be accomplished in conjunction with maintenance checks when conducted by contract personnel.

**Concern 3:** The L-1 forward door was open with a galley service truck on-loading a wheelchair passenger, which is contrary to CALA's "Before Start" checklist, where all doors are to be checked closed with the door warning lights not illuminated. This was done during the high power engine run-up.

**Response:** Based on the results of the investigation to date, it is known that the L-1 door was not closed. The cited checklist does require that a check be made to be certain all doors are closed. However, since there was no published guidance for the performance of maintenance engine runs, it appears the crew departed from all checklists to follow the verbal instructions from the mechanic. This was found to be a deficiency. This is being included as part of the SAT review.

**Concern 4:** The pilots did not get air traffic control's (ATC) approval to accomplish the high power run-up.

**Response:** This is a true statement. There is no published guidance at ELP requiring the pilots to request ATC approval prior to accomplishing an engine run-up. This is being included as part of the SAT review.

**Concern 5:** The pilots did not make a maintenance logbook entry for the mechanic to review.

**Response:** This is a true statement. This was found to be a deficiency. This is being included as part of the SAT review.

**Concern 6:** The pilots did not contact their CALA Maintenance Control with the nature of the discrepancy to obtain recommendations for procedures to follow.

**Response:** This is a true statement. This was found to be a deficiency. This is being included as part of the SAT review.

**Concern 7:** Mr. Thrash developed a series of interview questions for the pilot crewmembers, and his attempts to interview them were denied.

**Response:** Mr. Thrash did develop a series of interview questions for the pilot crewmembers, which were subsequently utilized during the Aviation Safety Action Program (ASAP) Event Review Committee (ERC) interviews. An airline denying the FAA access to crewmembers after an accident is a common practice during an investigation. CALA did deny the FAA, as a whole, access to the crewmembers, not

solely Mr. Thrash. Once FAA was granted access, the FAA inspector in charge, or his designee, would have been tasked with conducting crewmember interviews.

The objective of ASAP is to encourage air carrier and repair station employees to voluntarily report safety information that may be critical to identifying potential precursors to accidents. ASAP provides for the collection, analysis, and retention of safety data that is obtained, much of which would otherwise be unobtainable. This data is used to develop corrective actions for identified safety concerns and to educate the appropriate parties to prevent a recurrence of the same type of safety event. An ASAP is based on a safety partnership that includes the FAA and the certificate holder, and may include a third party, such as the employee's labor organization.

The ERC is comprised of a representative from each party to an ASAP Memorandum of Understanding (MOU). The ERC is usually comprised of a management representative from the certificate holder, a representative from the employee labor association (if applicable), and a specifically qualified FAA inspector from the Certificate Holding District Office. The ERC reviews and analyzes reports submitted under an ASAP.

Mr. Thrash also submitted several suggested actions, which he believes the FAA should have taken in response to this accident. Each suggestion is addressed below:

**Suggested Action 1:** Emergency pilot certificate revocation on both pilots.

**Response:** At the time Mr. Thrash initiated his hotline complaint, the FAA's investigation into this accident was still in process. No factual information had been identified that would indicate any certificate revocation was appropriate.

**Suggested Action 2:** Not accept the event into the ASAP, due to the pilot's intentional egregious, careless, and reckless operation of the aircraft at high-power settings.

**Response:** A review of the facts surrounding the actions of the pilot crewmembers determined the actions of the pilots do not meet the definition of intentional, egregious, careless, and reckless behavior, as defined by Title 14 of the Code of Federal Regulations (14 CFR). A careful examination of the grounds under which the pilot reports were accepted into ASAP was conducted. It was determined that the CALA ASAP ERC accepted the reports in a manner consistent with the FAA's advisory circular on ASAP, as well as with the ASAP MOU with CALA. This ASAP event remains open pending the conclusion of the NTSB investigation and completion of any required corrective actions.

**Suggested Action 3:** Issue Letters of Investigation (LOI) to both pilots for alleged violations of the CFR concerning careless and reckless operation.

**Response:** An LOI is simply a notice from the FAA advising an airman it is believed that a regulation has been violated. However, since CALA has an ASAP program, it would not be prudent to initiate enforcement activity prior to review by the ASAP ERC. A review of the facts surrounding the actions of the flightcrew determined the behavior of the pilots

does not meet the definitions of intentional, egregious, careless, and reckless, as defined by 14 CFR requirements.

**Suggested Action 4:** Issue letter to both pilots for re-examination of competency under Provision 44709 of the FAA Act of 1958, as amended.

**Response:** What Mr. Thrash suggested was a re-examination of the pilots to be ordered while the investigation was still underway. This suggestion was made before any factual information had been identified that would indicate any re-examination was appropriate.

One item that arose during the review of this complaint was the lack of understanding of the ASAP process by the majority of the ASW ASI workforce. During April and May 2006, ASAP Skills Enhancement Training will be provided to all ASW personnel connected with the ASAP Program.

While it is understandable for Mr. Thrash to become emotionally impassioned by the horrific nature of this accident, it is vital to ensure that all decisions are based upon a full assessment of all of the facts. This will be accomplished by the SAT review.