Unfriendly Skies
20th and 21st Centuries

Author Rodney Stich’s Other Books

Drugging America
Defrauding America
Iraq, Lies and Cover-Up
Blowback, 9/11, and Cover-Ups
Subverting America: A Trojan Horse Legacy
Lawyers & Judges—American Trojan Horse
Terrorism Against America: External & “Internal Terrorists”
Unfriendly Skies--
20th and 21st Centuries

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BOOK REVIEWS

After the first printing of the *Unfriendly Skies* was published in 1978, the author received numerous favorable book reviews; reviews that expressed shock at the nature of the revelations. The *American Library Association* wrote in part, "*Unfriendly Skies* is a record of scandal, disaster, and heartbreak, that demands an accounting from the highest levels of the industry and government."

*Professional Pilot* magazine stated: "May make Watergate look like kid stuff." Famous editor William Loeb of *Manchester Union Leader* accompanied his review with the letter, "Note this review of your fine book."

The *Seattle Times* Magazine wrote: "the facts he cites are devastating, indicating dereliction of duty and responsibility by airlines and the federal authority supposedly checking on them." *Ballantine Books* wrote in an interoffice memorandum, "Blockbuster of a story."

*Bookviews* stated: "The author’s charges of an enormous scandal of collusion between corrupt aviation and government people that underlies the causes for many airplane crashes. He charges a cover-up of such proportions even the mass media don’t want to touch the story, and I must say, makes a good case."

Jan Frazer, reviewer for *Book Review*, wrote: "In this shocking book, Rodney Stich presents impressive evidence to show that a virtual ‘government Mafia’ does indeed exist."

*Seattle Times* reviewer, Larry Rumley, wrote: "The *Unfriendly Skies* [is] a shocking report ... the facts he cites are devastating, indicating dereliction of duty and responsibility by airlines and the federal authority supposedly checking on them."

An Airline Pilots Association officer wrote, "found it most interesting and ... agree with many of the points you made."

The second printing addressed even worse government corruption related to air tragedies. Ten years later, the latest printing is even more tragic and more alarming, making the earlier exposures described in these book reviews pale by comparison.

But despite these reports, nothing was done, the cover-ups continued, the crashes continued, and on September 11, 2001, the consequences were greater than ever before. Still, nothing but cover-ups, insuring that the past will be repeated in the future.
INTRODUCTION

This Edition of *Unfriendly Skies* is something like an encyclopedia of airline crashes and disasters covering the period from the second half of the 20th Century into the beginning of the 21st Century, as viewed through the eyes of a former federal aviation safety agent. It will be seen that the number of airline crashes in the later period are far fewer than the earlier days of aviation. The primary differences responsible for the far fewer aviation tragedies include the following:

- Aircraft systems are more reliable, thereby eliminating the problem of system abnormalities being incorrectly handled.
- Jet engines are far more reliable than the piston engines, thereby eliminating mishaps due to engine failure or the incorrect handling of such failures.
- Jet engine failures do not pose the immediate danger that exists when a piston engine fails and there is a wind milling propeller acting like a barn door. When a piston engine failed, especially during takeoff, it required immediate and correct pilot input, something that is not necessary with jet aircraft.
- Installation of aircraft systems that correct for pilot failures, such as ground proximity warning systems to reduce the chance of flying into terrain; and a system warning of conflicting air traffic to compensate for pilots who fail to watch for outside traffic.
- Greater observation of aircraft movement by ground personnel and radar, warning pilots when they are flying too low for surrounding terrain.

The one problem that hasn’t changed and which occasionally plays an enabling role in aviation disasters is the deep-seated culture in certain government aviation safety offices. This culture is described within these pages, and its involvement in recent aviation disasters will become clear. Discover from a top federal aviation safety inspector the documented FAA culture that made possible years of preventable airline disasters, including years of fatal hijackings that enabled hijackers to seize four airliners on September 11, 2001. A former FAA inspector, Navy pilot, airline captain, details and documents a pattern of malfeasance, misfeasance, nonfeasance, and corruption, and the cover-up of this misconduct by people holding key positions in the three branches of government.

There will never be an effective investigation into these matters because of the involvement of many people in key offices in the three branches of government. That is, unless enough people become informed and exercise some semblance of courage. In these pages discover, for instance:

- The documented corruption within the government’s air safety offices that repeatedly resulted in the deaths of air travelers.
• The corrupt tactics used against federal air safety inspectors to prevent them from carrying out the duties of the federal government’s aviation safety responsibilities.
• The cover-ups, the aiding and abetting, by the politically appointed board members of the NTSB.
• The pattern of cover-ups by the NTSB political board members, their falsification of accident reports, and the role these crimes played in subsequent disasters.
• The misuse of government offices and power by Justice Department lawyers and federal judges to silence a key government aviation safety inspector, and the deadly consequences of those obstruction of justice crimes—including links to 9-11.
• The truth behind the downing of Pan Am Flight 103, reflecting the endemic disinformation fed to the American public.
• Corruption through felony cover-ups in the executive, legislative, and judicial branches of government, all of which played key roles in the continuation of these preventable tragedies.

Juxtapositioned with the victims, who were no match for the government-funded corruption, is the detailed and documented corruption of people holding key positions of trust in the three branches of government.

The author brings the reader behind the scenes, as an insider, describing sordid activities never revealed by any other source. The book describes several decades of air safety corruption, and branches out into other segments of government misconduct that made it all possible.

This saga of corruption is heavily documented. It brings together the contents of administrative proceedings, judicial actions, government documents, the author’s experiences as a federal air safety investigator, as an airline and military pilot, and his evaluation of these happenings.

Safety statistics measure fatal crashes, and do not measure unacceptable threats endangering everyone who flies. The dangers that should not exist, but do exist because of the dirty politics of air safety, simply wait for the right combination of events to extract their brutal toll.

This and the other books have been written for two primary purposes: (1) to inform those people who want to be informed of the corruption endemic in the three branches of government; and (2) to motivate as many people as possible to show some semblance of outrage and courage to fight the corruption in government that continues to grow.

Butterfly Effects

Among the most important issues raised in these pages are the many deadly consequences from the “butterfly effects” of the corruption, the criminality, and the cover-ups, described within these pages. Among the most recent examples of the butterfly effect are the hijackings of four airliners on 9/11.
ABOUT THE AUTHOR

Rodney Stich has a long history of insider activities that provided him the training and the opportunity to discover vast areas of misconduct in government offices. These experiences have put him into close contact with dozens of other former and present government agents and other insiders who also discovered corruption in government.

Between their several hundred years of combined experience, exposed to criminal and even subversive activities in government, many of their findings are revealed in the books that Rodney Stich has written. The purpose of these books has been to inform those people who want to be informed, and reveal to them the hardcore misconduct that is inflicting great harm upon national security and the lives of countless numbers of people. Further, to motivate enough people to show long-overdue outrage, to show courage, and to show long-overdue patriotic reaction.

Aviation Background Started Before the Pearl Harbor Attack

The author’s background in aviation started while he was in the U.S. navy prior to the December 7, 1941, attack on Pearl Harbor. He had joined the navy at the age of 17 and after training he became a radioman on a PBY Catalina seaplane. He was based temporarily on Midway Island before the Japanese attack that was a major turning point in the war. He was selected for pilot training and received his Navy wings first as a Naval Aviation Pilot (enlisted pilot) and then as a Naval aviator (commissioned officer).

He became an instructor in advanced PBY training at Jacksonville, Florida and then training as a Patrol Plane Commander in the Navy PB4Y-1 (Liberator) and PB4Y-2 (Privateer). Stich was the youngest Navy Patrol Plane Commander during World War II. Stich received his wings at the Pensacola Naval Air Station at approximately the same time that George Bush senior received his Navy wings at Corpus Christi.

Worldwide Commercial Airline Experience

After World War II, Stich flew for the airlines flying captain in domestic and international operations. He was checked out as captain on virtually every type of plane flown by U.S. airlines, including the double-deck Boeing Stratocruiser, Lockheed Super Constellation, DC-4, DC-3, Martin 202, Convair 340, Curtis C-46, Lockheed Electra, DC-8, and Convair 880.

He was one of the first pilots licensed by Japan, holding Japanese pilot license number 170. He was also one of the first captains for Japan Airlines, during which time his copilots were former Japanese military pilots from World War II.

The Saturday Evening Post had written a series of three articles in 1950 about the pilots at his primary airline, Transocean Airlines. The articles were titled, “The Daring Young Men Of Transocean Airlines.”

In those days, flying overseas, especially in the Middle East, were pioneering experiences, encountering situations that no airline pilot today
encounters. In one instance, in 1953, he found himself at the center of a revolution in Iran, which he later learned was engineered by the CIA. He flew Muslim pilgrims to Mecca and Medina on the Hajj during the Muslim holy period. He may have been the only pilot to take pilgrims to Medina, where he landed in the desert outside of the holy city. He resided in Jerusalem, Ramallah, Beirut, Tehran, and Abadan, visited Palestine refugee camps, and associated with the residents who were, in those days, friendly to the Americans.

He had his share of inflight emergencies, including engine failures, engine fires, sudden closing of virtually all airports at his destination, serious icing problems on the North Atlantic, sudden shortage of fuel when the head winds over long over-water flights became more adverse than forecast.

**Aviation Safety Agent for Federal Government**

Eventually he left airline flying and became a federal aviation safety agent for the Federal Aviation Administration (FAA). He was responsible for conducting flight checks of airline pilots, evaluating their competency, issuing government ratings, evaluating safety matters and preparing reports on safety problems and recommending corrective actions.

**Assignment To Halt Worst Series of Air Disasters in U.S. History**

Eventually, the federal government gave him the assignment to correct the conditions causing the worst series of airline crashes in the nation’s history. It was here that he discovered the deadly politics of air safety and corruption in government offices. To circumvent the blocks preventing the federal government from carrying out its aviation safety responsibilities, Stich exercised legal remedies in ways that had never before been done. He acted as an independent counsel, conducting hearings to obtain testimony and additional evidence that showed the deep-seated culture in the government’s aviation safety offices that enabled countless numbers of preventable aviation tragedies to occur. The events of September 11, 2001, would be one-day’s consequences of these serious matters.

Unable to correct the deep-seated corruption, Stich left government services and then engaged in other activities seeking to bring the corruption to light. Like a magnet, these activities caused other former and present government agents and insiders to provide him with additional information and evidence of corruption in government offices far beyond the aviation field. These were agents from the CIA, DEA, DIA, FBI, Customs, Secret Service, drug smugglers, and organized crime figures.

**Trojan Horse Corruption and David Versus Battles**

The magnitude of the corrupt and Trojan horse-like criminal and subversive activities, and the harm resulting from them, caused Stich to spend the remainder of his life fighting the escalating corruption in the three branches of government. No other government agent, or whistle-blower, revealing hardcore corruption in government offices, had suf-
ffered such great harm, as he engaged in years of escalating David versus Goliath battles to protect national interests and halt the harm being inflicted upon the people.

**Over 3,000 Radio and Television Appearances**

He has appeared as guest and expert on over 3,000 radio and television shows since 1978, throughout the United States and in Canada, Mexico, and Europe. For more information put “Rodney Stich” into Internet search engines such as www.google.com. For more information about his various books, go to www.defraudingamerica.com and www.unfriendlyskies.com.

The author, in his Twin Engine Beech, before federal judges seized all his assets, along with other actions, seeking to halt his exposure of widespread corruption in government offices.
The description of misconduct in the government’s aviation safety offices starts with an air disaster that occurred during the Christmas season, December 16, 1960. It was the world’s worst air disaster at that time and in some ways it is still the most brutal air disaster ever to occur in the United States or anywhere.

That disaster was one in a series of aviation disasters that caused the federal government to give me the assignment to correct the conditions resulting in these tragedies. In those days, the FAA was a much smaller organization and the number of aircraft in the nation’s commercial aviation sector was also much smaller. So it was not so unusual for one federal aviation safety agent to be given this assignment.

The airline responsible for most of these record numbers of airline crashes was United Airlines, and it was here that the blame met the definition of corrupt and criminal activities. The relatively fewer crashes by all the other airlines combined were due to a more innocent type of recognizable and ignored problems.

**List of Prior Airline Tragedies**

Prior to United Airlines’ New York City crash the airline had experienced many others. The United Airlines crash that was the catalyst for the formation of the FAA was the crash over the Grand Canyon when a United Airlines DC-7 crashed into a TWA Constellation. Part of the wreckage is still visible in the canyon.

This legislation was effective in part because a competent FAA administrator was appointed who knew what had to be done and who ordered major safety training and competency check requirements. This helped, but in the situation that existed at United Airlines (UAL).

**Oakland**

One United Airlines crash occurred within about four miles of my home in California. I had just moved to California and was a pilot for Transocean Airlines that was based in Oakland, California. The United Airlines pilots on Flight 615 misread their instrument approach chart and descended too low during an ILS instrument approach to the Oakland Airport. The plane crashed into hills near Hayward, just east of Oakland,
California. (August 21, 1951) Everyone perished.

**Salt Lake City**

United Flight 610, from Salt Lake City to Denver, crashed into a mountain near Fort Collins, Colorado, on June 30, 1951. The crew took a short cut at night and crashed into Crystal Mountain, thirty-five miles west of course. United Airlines also lost a Boeing Stratocruiser during training near San Francisco shortly before these two crashes occurred.

**“There won’t be a United Airlines if these crashes continue!”**

During this series of back-to-back crashes I had started flying for Transocean Airlines out of the San Francisco area. The pilot grapevine said that United Airlines officials held a pilot meeting in 1951 at San Francisco Airport, warning the pilots “There won’t be a United Airlines if these crashes continue!”

But the crashes continued, and for good reason. The training program was a shambles; United deprived the flight crews of training safeguards that would have prevented the gross errors associated with these crashes and those that continued for the next thirty years.

**A Few Key UAL People**

**Responsible for the Crashes and Deaths**

I discovered that a few key people in the United Airlines Flight Standards were responsible for the worst training program I had ever seen, the denial of training to those who needed it, and the anything-goes competency standards that deprived pilots and engineers of legally required training.

These tactics saved the airline considerable money and made those key UAL employees look good. Despite the year in and year out aviation calamities, the deaths caused by their conduct never altered their conduct. And this is what I initially fought, followed by concurrent fights with corrupt FAA management.

**United Airlines Crash Into New York City—**

**World’s Worst Air Disaster at That Time**

United Airlines Flight 826, a DC-8, departed Chicago’s O’Hare Airport on a non-stop flight to New York City’s Idlewild Airport (since renamed John F. Kennedy Airport). Taking off from Cleveland Airport, and also heading for New York City, but landing at La Guardia Airport, was TWA Flight 266, a tripletail Constellation.

One of United Airlines two VOR navigation receivers was inoperative, and known to be so by the crew. Good judgment dictated that the crews notify air traffic control of its inoperative receiver so as to receive extra radar assistance. The crew did not do this. ATC cleared Flight 826 to Preston Intersection, formed by the crossing of two radials from nearby VOR navigational radios. (Two VOR receivers are used to deter-

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1 Primary navigational receivers with which pilots determine their position (except on long over-water flights). The VOR units are combined with DME (distance measuring equipment) to provide radial (magnetic bearing) and distance information with respect to the VOR station.
mine the holding fix.) One receiver could do this under some conditions in less-dense traffic and holding conditions, but in the congested New York City area, it was foolhardy and obviously dangerous not to request radar assistance to determine the holding fix location. Further, a slower approach speed than normal was dictated by the loss of the second navigational receiver.

Instead of arriving at the low-altitude terminal area holding pattern at approach speeds of approximately 200 knots, United Flight 826 approached it at almost 500 miles per hour. At this speed the aircraft could not remain within the protected airspace of its assigned holding pattern even if the crew could accurately determine their holding position. A parallel to this would be a car making an 180-degree turn. At a slow speed, for instance, ten miles per hour, the amount of ground covered during the reversal would be much less than if the turn was made at forty miles per hour.

Airspace allotted for holding patterns are based upon an aircraft at a holding speed and not at a much faster cruising speed. TWA was approaching its New York City destination at approximately the same time that United 826 shot through its holding fix. Both planes were at 5,000 feet. The La Guardia air traffic controller cleared TWA for an ILS\(^2\) instrument approach to runway 04, landing to the northeast. Drizzle and low-level clouds covered the New York City area.

Following the TWA blip on his radar screen, the La Guardia controller directed TWA toward the narrow ILS course that guided planes to the La Guardia runway. Unknown traffic suddenly appeared on the radar screen moving rapidly toward TWA, its altitude unknown. In 1960 the aircraft did not have altitude-encoding transponders and the radar did not show the other aircraft’s altitude. Because of the high speed of the suddenly appearing traffic, the controller assumed it was high altitude en-route rather than low-level approach traffic. But the controller routinely alerted TWA to the converging traffic, “Traffic at two-thirty, six miles, northeast bound.”

**The Missing Radar Blip**

TWA was in the clouds and could not see the reported traffic. Again the controller advised TWA, “That appears to be jet traffic off your right now, three o’clock at one mile, north-east bound.” United, slowing down but still traveling at almost six miles per minute covered this one-mile separation in seconds. At 10:23 a.m. the two radar blips merged, indicating to the radar controller that the flight paths crossed, presumably at different altitudes. But that was not to be.

**The Sound of an Open Mike**

The sound of an open microphone pierced the air, as if an aircraft was trying to make a radio transmission. The La Guardia controller gave TWA a heading change to intercept the final ILS approach course. TWA

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\(^2\) Instrument Landing System precision approach that provides lateral direction and a glide path to the runway.
didn’t answer. Again, the controller radioed, “Transworld 266, turn fur-
ther left one zero zero.” Again the call went unanswered.

The controller suddenly realized what might have happened. He
quickly contacted Idlewild approach control to determine if one of their
planes was missing. It was soon obvious that the lost traffic was United’s
DC-8. There were now two large airliners missing over the New York
City area, with ominous signs that they had collided.

One of the passengers on United Flight 826 was Stephen Baltz, a
young boy traveling by himself. As he looked down at the white mantel
of snow covering New York City the plane shook with a loud thud as the
collision occurred. One of United’s jet engines rammed into TWA at
nearly 400 miles per hour, splitting open TWA’s fuselage, and scooping
out of the TWA cabin a woman passenger. Slowly she was fed into the
knife-like fan blades at the front of the jet engine.

The airport control tower operator at Miller Army Airfield on Staten
Island watched in horror as three large sections of the TWA plane hurled
through the base of the overcast, trailing flames and smoke. Two explo-
sions occurred just before hitting the main fuselage hit the ground, caus-
ing the wings to rip from the fuselage, followed by the separating tail
section.

As the pieces rained down upon them, two workers loading a furni-
ture truck on Hyland Boulevard dashed inside for protection. The pieces
fell like shrapnel. One later recalled, “I prayed that it would be over
soon.” Parts of the wreckage narrowly missed a community of homes,
tall apartment buildings and public schools, containing thousands of peo-
ple. It was pure luck that the death toll did not include them. The falling
fuselage and wing sections hit the ground with an ominous heavy thud.
The impact ejected more passengers onto the snow-covered ground, turn-
ing the snow bright red.

The open spaces of Staten Island permitted an unobstructed view of
this drama, and alerted rescue vehicles that rushed toward the expected
crash site. Witnesses on the ground stared in shock at TWA’s spiraling
descent. People watched in horror as the downward spiraling plane
ejected passengers out of the aircraft.

As the rear half of the TWA fuselage plunged toward them, a fear-
stricken mother grabbed her six-year-old daughter and ran for her life.
The huge fuselage section struck the ground fifty feet away, splitting
open like a lobster shell, and ejecting more people into the snow.

“I thought it was a bombing!”

Sitting in his third floor apartment on Staten Island, a Minister felt
the earth shake as the first part of the TWA plane hit nearby. “I thought it
was a bombing,” he later said. “I saw the plane fall in flames and smoke,
and a black object fell in front of my home. It looked as though the plane
was going to fall on the housing development, but it missed.”

Washing windows in her Staten Island home, one woman saw United
on a collision course with TWA, and then saw the crash itself. She later
exclaimed, “I saw what I believe to be the right wing of the other plane fall. It spiraled down at an angle toward Hyland Boulevard. I saw the fuselage was on fire.”

“It went down in a terrible way.”

“Listen to the thunder,” exclaimed one woman to her niece. She later explained, “I rushed to the window and I saw this terrible ball of fire. It was huge, and it must have been a mile off.” She continued, “I watched, and it was terrible. We could see now it was a plane. It seemed to fall a few feet and there was another huge burst of flame. And then the plane went down. It went down in a terrible way.” She recalled, “One wing gone, it turned over and over very slowly. You could watch it. All the way it was always red from the flames.”

Sitting in his radio car, a Staten Island dispatcher for the Transit Authority buses suddenly heard a loud noise, “like a jet breaking the sound barrier.” Looking up, he saw a sight he would remember forever. He described it as “parts of bodies falling from the plane.” Quickly starting his car, the dispatcher picked up a nearby foot patrolman and the two of them sped toward Miller Field where the wreckage was expected to crash. By radio they alerted the bus terminal dispatcher, who in turn notified police.

They stopped several times on their way to Miller Field, gathering bloody human remains that had fallen from the spiraling plane. At the crash scene, they placed more human remains in the radio car. Impaled on a nearby tree was a woman, still bleeding.

“I prayed that it would be over soon.”

At a nearby shopping center, two brothers, Peter and Gerard Paul, threw down their purchases, and ran to the crash scene, vaulting a ten-foot cyclone fence. The first to arrive, the bloodied and dismembered bodies overwhelmed their comprehension. Pulling out his knife, Peter cut the safety belts from three people, two men and a woman, who moaned in pain. Arriving soldiers from nearby Miller Field helped remove these three people who barely clung to life by a thread. They placed two of them into a Coast Guard helicopter that flew the painfully injured men to the New Dorp United States Public Health Hospital. Others drove the woman to the hospital by car. The only one of the three to reach the hospital alive died a few hours later.

“It was very quiet inside the aircraft,” they later said, “except for occasional moaning.” Peter stated, “I prayed that it would be over soon.”

Fire apparatus reaching the crash scene cut through the same wire fence that the Paul brothers had earlier vaulted. They directed water hoses to the now fiercely burning forward section where the passengers fared even worse than those in the separated rear section. Arriving rescuers reeled at the sight of dismembered and decapitated bodies.

Later, after nothing more could be done for the victims, a solemn crowd gathered on the far side of the nearby cyclone fence. They stood quiet and looked sad, shocked by the great tragedy. They had difficulty
comprehending the magnitude of the horror. Yellow insulation from the
doomed TWA plane interlaced the bare branches above their heads, fes-
tooned as if in celebration for Christmas.

“God brought that plane in,” said Colonel E. Howan, Commander of
Miller Army field, as he stood at the crash scene. He noted that the fall-
ing aircraft sections miraculously missed many homes and apartment
buildings. United’s jet engine, torn from the wing by the initial impact,
buried itself in the frozen ground of an empty playground. Still inside the
engine were the remains of the ingested passenger.

Elsewhere, the Horror Continued

It was all over for the passengers and crew of TWA Flight 266. But
the horror continued for those on United Flight 826. After ramming
TWA, and losing one of its engines, Flight 826 proceeded for eight miles
in a northeasterly direction, losing altitude as it descended toward the
heavily congested Brooklyn section of New York City.

The only noise on Brooklyn’s Sterling Place was the occasional
sloshing sound of a car going through the snow. But this shortly changed.
Thousands of people on the ground in New York City watched the DC-8
streaking toward the densely populated Park Slope residential and busi-
ness section. Flight 826 swept in low, and just before impact, threatened
to crash into St. Augustine parochial school that contained over a thou-
sand children.

Two men shoveling snow at the intersection of Sterling Place and
Seventh Avenue suddenly heard the whine of jet engines. They looked up
and saw the DC-8 coming straight at them.

A Brooklyn teacher, James Barnes, noticed a student suddenly turn
pale. Barnes looked in the direction the student was staring, and saw the
cause of the fright. The DC-8, not over a thousand yards away, was de-
scending straight for the school. Suddenly the plane banked to the right,
barely missing it.

At over 200 miles per hour United’s right wing rammed into a
brownstone apartment building, spinning the jet’s nose section directly
into the Pillar of Fire Church. The three-story building instantly disinte-
grated, erupting into a fiery inferno. The crumbling church buried Wal-
lace Lewis, the caretaker, in the rubble.

The DC-8 tail section crashed into the intersection in front of a small
grocery store. A blazing section of the left wing thrust itself into a nearby
division four-story apartment building, its tip protruding grotesquely through the
shattered roof.

A large section of the cabin, with passengers trapped inside, slammed
against McCaddon’s Funeral home. Immediately before the crash, the
McCaddon’s were having mid-morning coffee in their apartment over the
funeral home. Suddenly, Mrs. McCaddon exclaimed, “My goodness, that
plane sounds awfully low!”

Just then the entire building shook, as if hit by a bomb. Flames
leaped into the air outside the broken windows. Grabbing their baby, the
McCaddin family ran for their lives.

The Pitiful Sound of the Dying

From inside the DC-8 wreckage came the pitiful, tortured screams of the dying crew and passengers. A bystander later described the cries as “the worst sound I ever heard.” The first to arrive on the crash scene could see and hear the passengers screaming in pain. They could offer no help. Trapped and hopelessly beyond aid, those inside the wreckage felt the terrible heat and hopelessness of their final moments.

A young boy, injured by falling debris, ran from the crash scene, blood streaming down his face. He shouted as he ran past a flower shop, “Oh, those people are burning to death.” His eyes showed the horror he had just seen. A man grabbed the boy and shook him, but the boy pulled away and ran. A woman, unaware of the tragedy that had just occurred, stated, “He must be out of his mind.”

“Am I going to die?”

Not everyone perished on Flight 826. The owner of a small grocery store, stacking milk containers in the rear of the store when the crash happened, ran to the front door, pulled it open, and saw the astonishing pandemonium only a few feet away. Suddenly, he saw a little figure crawling from the burning tail section.

His clothes on fire, covered with blood, and bleeding from his nose and mouth, Stephen Baltz crawled slowly and painfully from under the flaming wreckage. Two patrolmen arrived on the scene as Stephen crawled on the ground. They quickly rolled Stephen in the snow to extinguish his burning clothes. After extinguishing the flames, a woman in a leopard coat held an umbrella over Stephen to protect him from the light rain. It was a sad scene.

“Am I going to die?” Stephen asked, looking up, and crying in pain. Stephen reached out for help. His lips quivered as he cried, “Mommy, Daddy...”

Completing his services at nearby St. John’s Episcopal Church, Reverend Harry Sterling rushed outside as a police officer ran up and asked him to give absolution to Stephen. Together they rushed to the flaming wreckage, finding Stephen still conscious. The smell of burning flesh worsened the horror.

“Mother...she’s waiting for me.”

The flames burned Stephen’s face, hair, eyelashes, and lungs. He kept holding up his right arm, showing his bleeding hand. Rushed by police car to nearby Methodist Hospital, Stephen lay in the arms of Mrs. Dorothy Fletcher, Chief of the Brooklyn Volunteers for Civil Defense. Just before lapsing into unconsciousness Stephen sobbed, “Mother...she’s waiting for me.” It was only by chance that Stephen had been on this United Airlines jet. Stephen was to have flown two days earlier with his mother and younger sister, Randee.

Initial Signs of an Airline Crash at the Passenger Terminal

At the airport terminal, families and friends, unaware of the crash,
became more anxious every time the airline personnel changed the aircraft’s expected arrival time. After several such delays, ticket agents removed the flight’s listing from the flight board, providing the first hint of the disaster, although the public didn’t recognize the omen at the time.

Finally, a United Airlines employee, holding back tears, announced that United 826 would not arrive; it had crashed. Cries and screams erupted. In the background gala Christmas music sounded through the terminal.

“What am I going to do, what am I going to do?” sobbed one young woman, waiting for her husband who would never arrive. Others tried to comfort her, saying that he was still alive. “No, no, there’s only one survivor,” she cried, a fact she learned from news reports of the tragedy on TV.

Throughout New York City sirens pierced the air, as over fifty pieces of emergency equipment rushed to the disaster scene. It was probably the worst disaster the nation’s largest city had ever experienced.

Wallace Lewis, caretaker of the nearby Pillar of Fire Church, had not purchased a ticket for a flight in the friendly skies of United, but he was affected by United’s “friendly skies.” He died in the destroyed church.

“An act of God.”

Fire Commissioner Cavanaugh said it was “an act of God that the major impact of the crash had been on the vacant church rather than on any of the surrounding buildings heavily occupied with tenants.”

Tons of Human Remains

The crash caused dismemberment or cremation of twenty-six thousand pounds of humanity. Two hours after the initial crash, the Brooklyn fire department declared the fire under control. The gruesome task of removing and identifying the dead then began.

Lining the streets and watching from apartment windows, quiet and visibly shaken onlookers watched the grim procession of stretchers carrying blackened, mutilated and bloodied bodies. City officials declared an unprecedented citywide emergency by sounding the emergency disaster signal.

The only living survivor of those last desperate minutes described the experience from his hospital bed. Stephen described the beauty of the snow-covered city as the DC-8 descended. He described the fear he felt as the plane plunged toward the ground. Stephen added, “That’s all I remember until I woke up here.”

Stephen’s father rushed from Chicago by plane to reach his badly injured son. Landing shortly after dark, a police escort rushed him to the hospital. Later, Mr. Baltz said, “My son tried to smile but could not.” Medication covered Stephen’s badly swollen face. The crash broke Stephen’s left leg, and the ensuing fire inflicted burns on a major portion of his body. Stephen was in critical condition, and doctors expressed fear that searing of his lung tissues had occurred.

Stephen’s mother and father stayed in a room at the hospital so they
could be close to their son. The morning after the tragedy, Stephen felt well enough to ask his father for a book, and permission to watch television. Chances for his survival improved. Shortly before Stephen lapsed back into unconsciousness, his father promised him a portable television set for Christmas.

Thousands of telephone calls and telegrams poured into the hospital from all over the nation, expressing hope and prayers for Stephen’s recovery. It was only eight days until Christmas; it would be cruel if Stephen didn’t make it after suffering so terribly.

**Stevie Joins the Others in Death**

The nation’s prayers, the intensive medical help, could do only so much. Stephen’s parents maintained a constant vigil at his bedside. Whatever plans Stephen’s parents had for his future, whatever dreams young Stephen had, they all ended. He died.

A heartbroken father, his eyes misting and his voice breaking, stated to the press: “Well, our Stevie passed away at one p.m. His mother and I are tremendously saddened. But we have had so many fine people in the world send sympathy and prayers and we want to thank them. Stevie tried hard; tried awfully hard. He was a wonderful boy, not because he was my son, but because he was Stevie.”

The hospital staff issued a bulletin: “All could not bring the little boy back from the effects of his severe injuries. He closed his eyes and went to sleep.”

The task of identifying the horribly mutilated bodies remained. A Bellvue hospital morgue attendant said, “The bodies are so badly mangled, even worse than those from the Morro Castle. It is the worst I’ve seen in my thirty-eight years here.”

Saddened relatives and friends climbed the fourteen steps leading to Bellvue city morgue from the early morning hours and late into the night. The morgue staff avoided personal identification whenever possible. One attendant said, “It’s an ordeal we don’t like to put people through if we don’t have to.” But fingerprints and dental charts did not always spare the next-of-kin the tragic ordeal of identifying a loved one.

The human suffering in the disaster, as in many others, was indescribable. For some of the friends and relatives, the emotional and financial suffering continued for years afterwards. Financial settlements often occur years after the crash, and by then the legal costs and attorneys’ fees take much of the final settlement, leaving very little for those who need it most.

**Politics of Accident Investigation**

By law, the National Transportation Safety Board (NTSB) investi-
gates airline crashes. In addition to its own investigators, the NTSB is assisted by people from the FAA; aircraft, engine, and accessory manufacturers; from the airline; and from the pilot’s union. They also have a vested interest in protecting themselves.

Shortly after the NTSB accident investigators arrived at the Brooklyn accident scene, they found the aircraft flight data recorder in the rubble of the Pillar of Fire Church. It provided information on the plane’s speed, altitude, direction, and time, which was then compared with radio communications and radar information.

It was obvious that the United Airlines captain badly mishandled the flight by speeding into a low altitude holding pattern area, compounded by failure to notify air traffic control that one of his navigational radios was inoperative. This was the direct cause of the crash. And the NTSB reported it correctly. But what the NTSB omitted from the report was a scandal that to this day has never been officially released. If the records had been released, they would have exposed the arrogance and corruption at UAL and within the FAA that enabled this and other airline tragedies to occur. These were the underlying causes of the nation’s worst air disaster and would play underlying roles in crashes occurring for many decades thereafter. The NTSB cover-up was a felony under federal law.6

NTSB and FAA management withheld from the official accident report the many FAA inspector reports that caused the conditions to exist that result in the tragedy. Covering up for these serious deep-seated problems and culture continued the status quo—and the expected continuing airline disasters and deaths. Doctoring government records become capital offenses under federal law7 when death follows. With each subsequent resulting crash—that could have been prevented if the cover-up had not occurred—it became necessary to continue the cover-ups. And this culture exists to this day.

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6 Title 18 U.S.C. § 35. Whoever imparts or conveys or causes to be imparted or conveyed false information, knowing the information to be false, ... to do any act which would be a crime prohibited by this chapter or chapter 98 or chapter 111 of this title shall be subject to ...

Title 18 U.S.C. § 1001. Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined ... or imprisoned ...

(a) Whoever ... conceals, removes, ... or destroys ... any document ... filed with any public officer of the United States, shall be fined ... or imprisoned ...

Title 18 U.S.C. § 34 Penalty when death results
Whoever is convicted of any crime prohibited by this chapter, which has resulted in the death of any person, shall be subject also to the death penalty or to imprisonment for life.

7 Title 18 U.S.C. § 34. “Whoever is convicted of any crime prohibited by this chapter, which has resulted in the death of any person, shall be subject also to the death penalty or to imprisonment for life, ... “
**Air Safety Corruption**

Before this crash, FAA inspectors repeatedly complained that:

- The UAL training program was dangerously unsatisfactory.
- Many of the United Airlines FAA approved company check airmen deprived the crewmembers of legally required training.
- United Airlines deprived weak crewmembers corrective training.
- That United Airlines engaged in a pattern of violating important air safety laws by not providing recurrent training to its flight crewmembers.
- Did not check the competency of the flight crews, as required by law.
- Government required records were falsified to indicate legally required training was provided when in fact the training and competency checks had not been performed.
- FAA management knew of these safety problems and violations, blocked the correction of them, and retaliated against government inspectors who made such reports.

These were serious federal crimes and made into capital offenses under federal criminal and air safety statutes, including Title 18 U.S.C. Sections 34 and 35.

Similar to the savings and loan and many other government scandals, FAA inspectors who discovered serious fraud relating to violations of the government air safety requirements were blocked from taking corrective actions. FAA and United officials obstructed compliance with the air safety laws, with the assistance of members of Congress, just as in the HUD, savings and loan, and other scandals.

**Sequestered Reports of Criminal Activities**

By law the FAA, through its inspectors, inspects and determines whether the airline meets federal air safety requirements, and determines whether an adequate level of safety exists. The FAA approves company pilots to act in place of the FAA inspectors, and then the inspectors observe a percentage of training and competency checks conducted by airline check airmen to insure that FAA standards are met. If they don’t meet FAA standards, the airline’s check airmen are to be removed from that function. In real life, it was the inspectors who were removed. In reality, it was the FAA inspectors who were removed when they reported FAA standards were violated by FAA-approved company check airmen.

FAA inspectors repeatedly reported check airmen at United Airlines engaging in questionable practices, having low standards that reduced the training costs, and depriving the crewmembers of the safeguards that come with a good training program.

**Falsified Training Records**

Several months before this crash, FAA inspectors traveled from the Denver training center to United’s maintenance base at San Francisco, to crosscheck the aircraft records with the Denver training records. The intent of this unusual cross-check of records was to determine if United officials were falsifying training records and withholding training to the
crewmembers, as the inspectors suspected.

The cross-check revealed that the legally required training and competency checks that required three to three and a half hours to complete when FAA inspectors were present, only required thirty to forty-five minutes when inspectors were not present. Obviously, UAL check airmen were falsifying the training records, and not providing the flight crews the legally required training. United covered up for this by falsifying the training records. This was very serious, especially now that the same program experienced the world’s worst air tragedy.

On October 16, 1960, the inspectors conducting the unexpected inspection signed an eight-page report prepared by FAA inspector Frank Harrell, describing their findings. That report became an official government document, and should have been the primary evidence in the NTSB investigation of the New York City air disaster. That report, and many similar reports in the FAA files, explained why the DC-8 crew mishandled the aircraft as badly as they did.

That document would have revealed why the UAL pilots handled their DC-8 in such a dangerous manner, and why the reported problems were blocked from being corrected. The report was a blockbuster and would have shown the United States in the world’s worst air disaster scandal.

**FAA Response for Reported Safety Problems:**

**Destroy the Report!**

After that alarming report was filed as a government document, and before the New York City crash occurred, FAA Western Region officials engaged in a cover-up that would cost hundreds of people their lives. Instead of forcing United Airlines officials to comply with the law, and provide the legally required training, FAA officials sequestered the report, which was another felony.

**Continuing the Same Deadly Fraud**

The next step was to get rid of FAA inspectors who embarrassed the FAA and NTSB with sensitive reports. The primary FAA inspector responsible for UAL’s DC-8 program was Frank Harrell, whose determination to correct the unlawful and dangerous training program put him in frequent confrontation with United Airlines officials.

Harrell was also the FAA inspector responsible for the inspection team visit to United’s San Francisco maintenance base, which led to the discovery of training record and training falsifications. United officials put pressure upon FAA management to get rid of Harrell, and this was done. The FAA Western Region transferred Harrell to an undesirable job in Puerto Rico, which inspectors associated with their version of Siberia. This move sent a warning to other inspectors not to report safety violations or safety problems at United Airlines.

The cover-up continued the conditions that made the crash possible. Other crashes, and other deaths, naturally followed, making the FAA and NTSB cover-up contributory causes to the tragedies. These will be ex-
Cover-up Response by Pilots’ Union

The UAL training program irregularities were obviously known to the pilots and the pilots’ union; Airline Pilots Association (ALPA). The union made no attempt to exonerate the crew of Flight 826, which they could have done by exposing the training program misconduct that preceded the crash. Instead, ALPA claimed that the crash was the fault of air traffic control, implying that the controllers on the ground should have been able to halt the aircraft in the sky like a traffic cop.

Warnings Two Days Before the Crash

Ironically, two days before this crash the head of the Federal Aviation Agency, Air Force General E.R. Quesada, testified before the House Commerce Subcommittee on airline safety. Quesada identified the obstacles and roadblocks confronting aviation safety: Airline Pilots Association (ALPA) and the Aircraft Owners and Pilots Association (AOPA). Aviation Week & Space Technology reported his testimony:


In his two hour, 47-page testimony, Quesada told the subcommittee that when he became Administrator of the newly created agency on Nov. 1, 1958, “I was by no means naive as to the past history of the AOPA as a self-serving group. But I must admit I was not fully prepared for the intensity of their invective or for the imaginative and sometimes devious methods they employ.”

Declaring that he refused to allow the pressure groups to intimidate him or FAA inspectors, Quesada presented a case-by-case list of AOPA and ALPA attacks on government safety activities. He urged the subcommittee to insist on effective administration of the new government air safety agency.

FAA Administrators come and go, and Quesada probably did not know the bureaucratic corruption that existed deep within the FAA (which was especially rampant in the FAA Western Region). Although United’s executive offices were in Chicago, and the FAA office at Chicago would have been the one holding safety responsibilities for United, the certificate was held by the Los Angeles FAA Regional Office, which had a cozy relationship with United Airlines officials.

The Public Never Learned the Truth

The public never learned the true cause of the crash. If it had become public knowledge, the lawsuits against United Airlines would have included punitive damages that were not covered by insurance. UAL contributed large sums of money to members of Congress; it was a source of
high-paying positions for former government employees; and it controlled powerful law firms. Further, the criminal acts included FAA officials, plus the bribing of members of congress with euphemistically called political contributions.

Lawsuits were filed against UAL, TWA, and the FAA, but without any of the plaintiffs knowing the truth behind the crash. The fuzzy argument for suing the FAA was that the FAA should have been able to stop the United DC-8 in flight. At the time of this crash, government air traffic services were already providing more assistance to pilots than ever before. The air traffic controller on the ground could not stop a plane that ignored its clearance limit and sped into the airspace assigned to other aircraft.

The total claims arising as a result of the disaster neared a third of a billion dollars. The *Journal of Air Law and Commerce* stated, “371 cases amounting to 153,000,000 dollars were pending” as a result of this crash. Claims against the United States Government, defended by the Department of Justice, were close to seventy million dollars. The amount would have been much higher if the next of kin knew of the misconduct at UAL, being legal basis for punitive damages. Because of the fraud, even today, UAL and the FAA could be sued as the statute of limitations does not start to run until evidence of the fraud is known to those with a claim.

Outspoken FAA Administrator Pete Quesada issued a statement based upon the evidence shown by the DC-8 flight recorder and other data. He either did not know of the internal FAA misconduct or he deliberately covered up. But he *did* warn that unless the FAA and the airlines paid greater attention to basic safety requirements, the tragedies would continue. And that did occur!

UAL management and the Airline Pilots Association each had an ax to grind against Quesada. Neither took kindly to Quesada’s requirement that the crews meet the stiffer training and competency standards than Quesada initiated. Even though this air tragedy showed the importance of training, United and ALPA blamed Quesada for the crash.

Despite Quesada’s warnings, the Chairman of the Senate Aviation Subcommittee, Senator Mike Monroney of Oklahoma, condemned Quesada’s control of the FAA, and eulogized the very groups that shared blame in the crash. *Aviation Week*, wrote:

> Monroney Increasingly Critical of FAA. Sen. A.S. Mike Monroney (D-Okla) made it clear last week that he intends to keep a closer, more critical eye on the Federal Aviation Agency as his Aviation Subcommittee continued its investigations of air safety. He made it clear that he has some misgivings about the uncritical support he gave the agency during its first two years and that he intends to keep FAA operations under close surveillance. Commending ALPA on its testimony...Sen. Monroney again raised the issue of whether FAA has exerted its full powers to promote air safety, and commented, “This is not a very good record. I don’t think we’re doing a good job.”
Monroney reportedly received healthy financial contributions from ALPA and other union and corporate interests. Under the direction and insistence of Attorney General Robert Kennedy, the United States Department of Justice acted to relieve United of considerable financial responsibility for the crash. This caused the public to assume a greater portion of the financial liability arising out of the air disaster. A World News Digest article stated:

**U.S. to Pay in Air Crash.** It was disclosed Oct. 22 that the federal government [i.e., the taxpayers] had agreed to pay 24% of the damages of verdicts agreed on in lawsuits growing out of the Dec. 16, 1960 collision over N.Y. Harbor between a United Airlines DC-8 jet and a Trans World Air Line Lockheed Super-Constellation. (134 people were killed.) United Airlines was to pay 61% of lawsuit damage costs; Trans World 15%.

The government was a co-defendant in the suits because the planes’ instrument landing approaches were being guided by Federal Aviation agency controllers when the collision occurred. A tentative government agreement to bear such a share of the damages had been canceled by FAA administrator Najeeb E. Halaby, but his decision was over-turned by the Justice Department. [See Vol. XXII, p. 256B-C3]

In the Journal of Air Law and Commerce a description appeared of the government’s settlement of the lawsuits arising out of the DC-8 crash into New York City:

On October 23, 1963, the United States Government, specifically the Department of Justice, agreed to pay twenty-four per cent of whatever damages are fixed as a result of claims and lawsuits arising from the collision of a United Airlines DC-8 jet with a Trans World Airlines Super Constellation over Staten Island on December 16, 1960.

United Airlines and Trans World Airlines agreed to pay sixty-one and fifteen percent respectively. ... It is interesting to note that if the case had been tried and lost, the Justice Department would have been responsible for paying the judgment out of its budget. However, since the case was settled, the FAA is liable out of its budget.

The article discussed the danger of executive department settling of claims, benefiting industry and added:

Would ... political considerations cause these standards to be stretched beyond those of even the most liberal court?

Voicing strong disapproval of this settlement, FAA Administrator, Najeeb Halaby (who followed Pete Quesada when his outspoken position caused his removal as head of the FAA), lambasted the settlement in an internal FAA communication:

I opposed this settlement formula at every level in the Department of Justice up to and including the Attorney General. My opposi-
tion was based on the fact that the system (referring to the air traffic control system) cannot either then or now reach out and prevent an accident involving an airplane which flies 12 miles past a holding fix at a great rate of speed...The Air Traffic Control system is very much like the system furnished to the highway users. The government authorities furnish the stop signs, the red and green traffic lights and the rules for their use.

The air traffic control system cannot physically prevent a pilot from disregarding a stop signal any more than the highway traffic control system can physically stop a vehicle whose operator disregards a red light and plunges through it. Both systems are dependent on and require responsible compliance on the part of the operator of the vehicle with the traffic rules. When a pilot is told to hold at a particular holding pattern and says he will, it is up to him.

The controller on the ground cannot pilot or navigate the airplane for him ... the system in December 1960 was not capable of stopping those who did not comply with directions from the controllers. Neither does it today, despite the many advances made in the past three years. Nor will it in the future, because it is generally agreed that ultimate responsibility must reside with the pilot ... the system was not violator proof nor will it be.

The Causes Continued as if Nothing Happened

After the New York City crash nothing changed at the FAA Denver district office and Los Angeles regional offices. Nothing changed at United Airlines. The competent and conscientious FAA inspectors continued to complain among themselves about the poor training and standards at United. FAA inspectors continued to observe United check airmen denying legally required training to the crewmembers. FAA officials continued to pressure inspectors not to report safety violations or safety problems. Harrell, the “trouble-maker” was gone, and the other inspectors grumbled among themselves. But they rarely filed any written reports of the continuing safety violations and safety problems. The “smart” politically attuned inspectors ignored the safety problems and violations, as they found that was the way to benefit in the FAA (as in every other government organization).

Deep-Seated FAA Culture Remained in Place

One of the key obstacles faced by FAA inspectors in trying to make the airlines conform to the law and meet adequate safety standards was the culture in the FAA that blocked the federal government from carrying out its aviation safety responsibilities. These problems emanated from a combination of factors: incompetence in management positions, revolving door syndrome in which people in government ignored major safety problems and safety violations of airlines for which they were seeking to be hired; laziness.

When pressure came from higher offices, the pecking order down below continued the status quo, despite the repeated crashes and deaths
arising from them. The power of higher management to rate the performance of personnel, to make promotions and higher pay, to pay bonuses, acts to spread the misconduct and discourage the more competent and dedicated from performing their air safety duties.

Inspectors face a culture that didn’t want reports of safety problems or safety violations, a culture that destroyed such reports and retaliated against those inspectors that sought to carry out the government’s air safety responsibilities.

One instance of this in the Western Region of the FAA was the well-known conduct by the chief of the Air Carrier Branch in Los Angeles, Lynn Ashwell. He was reportedly looking for industry support to become the first career administrator of the FAA at a time when most administrators were political appointees. To obtain industry assistance in reaching his goal, Ashwell applied pressure on inspectors not to report unsafe or illegal practices. I encountered this problem when I joined the FAA, and got into the thick of the problem when I accepted the assignment to take over the United Airlines DC-8 program.

After Harrell was banished to Puerto Rico, middle management FAA officials offered me the United DC-8 opening at Denver while I was working in Los Angeles with American Airlines, Western, and others. I was already aware of some of the problems on the United Airlines assignment. But after I accepted the assignment and moved to Denver, I found the problems worse than I had been told.

I had been advised that the United Airlines assignment was very difficult, but that I would get all the backing I needed. The first part of that statement was correct, and the second part was totally incorrect. There was no backing. Everyone in the FAA ran scared. United was a powerful corporation that controlled the FAA through congressional pressures. Mere air disasters weren’t going to change the status quo at UAL or within the FAA.

**UAL was Catalyst for FAA Formation**

Ironically, the Federal Aviation Administration was legislated by Congress through the Federal Aviation Act of 1958 because of an earlier United Airlines crash. Congress passed this legislation after a United DC-7 crashed into a TWA Constellation over the Grand Canyon on June 30, 1956. Both planes plunged into the Grand Canyon with the loss of all 128 people.

The former government air safety agency was the Civil Aeronautic Administration, managed by indifferent bureaucrats and responsive to political and vested interest groups. The Act granted the FAA the authority and responsibility to make and enforce air safety rules. Unfortunately, the Act brought into the new agency the same government bureaucrats and mentality from the CAA. Deeply ingrained in the CAA were government politics, favoritism, graft and corruption. These individuals, and this attitude, carried over into the FAA, preventing the conscientious inspector from functioning.
The horror of the New York City disaster faded from the public’s mind. The public soon forgot. The government withheld from the public the scandal behind that great air disaster. The cover-up made possible, or caused, many air disasters to follow. This book is a saga of scandals starting with the deaths of Stephen Baltz and 133 others.

Series of other fatal crashes at United Airlines (and to a lesser extent at other airlines) then followed for the next eighteen years, almost every one due to the known air safety problems and air safety violations.

United Airlines Crash Into Brooklyn Section of New York City

The United Airlines DC-8 crash into the Brooklyn borough of New York City was the world’s worst air disaster at time, based upon the number of people killed. It is still, today, one of the most brutal of all airline crashes, plunging deep into the heart of a major city. The misconduct and culture that made that crash possible continued for several decades to play major roles in other air disasters—the latest occurring on September 11, 2001.
Stephen Baltz, a victim of arrogance and corruption.

Deadly Survivable Crash at Denver
Seven months after the New York City crash, another United Airlines crash occurred, caused by the same training program problems. This one occurred in Denver, where United had its training base that was the root cause of many UAL crashes. Nothing had changed since the New York City crash. If anything, the defiance by UAL management to FAA safety requirements became worse with their success in escaping punishment for earlier tragedies. And FAA officials continued the culture, the arrogance, and the misconduct, as before. Very few inspectors dared to report the problems, avoiding the fate netted out to Harrell.

The weather at Denver was beautiful. Visibility was over forty miles and the temperature a comfortable and dry 73 degrees. It was great to be alive, truly vacation time in the Rockies. Any sign of what was shortly to mar this beautiful day was not apparent to those lining the visitors’ platform at Denver’s Stapleton airport, as they waited for the arrival of United Flight 859 on this July 11, 1961.

The captain of flight 859 was a veteran pilot with thousands of flying hours. If his training had met industry standards during his long career, he should have been a sharp pilot. His copilot was a former captain who had upgraded from the older piston equipment. United Flight 859 departed Omaha, Nebraska on what should have been a short and uneventful flight; one hour by jet, or one day by car. At 10:12 a.m. United 859 lifted off from Omaha, climbing swiftly toward its cruising altitude. The takeoff weight was almost 100 tons, but relatively light. The gross weight
eventually increased to twice that weight as more powerful engines were installed.

United DC-8 crash at Denver—Consequences of Fraud

As Flight 859 climbed through twenty thousand feet and passed overhead Wolback, Nebraska, the captain, who was hand-flying the jet, suddenly felt a brief tapping in the control wheel and felt a slight yaw to the right. Something was wrong.

Simultaneously, the amber warning lights for the powered flight controls illuminated, showing loss of hydraulic pressure to the aircraft’s rudder and aileron controls, indicating hydraulic system failure. The flight controls reverted from hydraulic boost to manual. (Aerodynamic boost now provided power to move the flight controls, and the backup for loss of hydraulic pressure to the horizontal stabilizer was provided by an electric motor.)

In accordance with the hydraulic failure checklist, the flight engineer moved the hydraulic pumps to the bypass position. At that point, no emergency should have existed. An abnormal condition existed, which any properly trained flight crew could safely handle. But an emergency did exist: The crew didn’t know the aircraft systems well enough to safely handle what started out as a relatively minor problem.

Safety was compromised by another problem in addition to its training problems. The airline used a reverse procedure that was dangerous. The procedure gave two crewmembers simultaneous and uncoordinated control of the aircraft. It was a procedure no other known airline or military organization in the world used.

A Cross Section of America

The passengers in the cabin were a cross-section of people from all walks of life. They were unaware of the existing serious safety problems, which would shortly affect their lives. Among the passengers were Mrs.
Earl Guyer and her three daughters, eight-year-old Cynthia, four-year-old Ann, and one-year-old June, returning home to Fort Lyon via Denver. Dr. Earl Guyer, clinical psychologist assigned to the Veterans Hospital at Fort Lyon, waited anxiously at the United Airline’s arrival gate for his family arriving on United flight 859.

**Routine Emergency Reaction**

Emergency vehicles with flashing lights sped toward the landing runway as Flight 859 approached, creating apprehension in those waiting for the flight. Dr. Guyer’s entire family was on the incoming jet. Upon touchdown, an aircraft is normally slowed by the pilot applying reverse engine thrust and brakes, ready to make differential changes in their application if directional control problems develop. Instead of a single pilot handling reverse thrust and braking (plus nose-wheel steering), United divided the tasks between both pilots. Directional control problems were frequent. FAA inspectors reported the procedure as unsafe, but FAA officials refused to order the procedure changed.

On that DC-8 model, the reverse system incorporated ejectors, which slide out to a fully aft position by hydraulic pressure. It was important that these ejectors remain fully extended and work in harmony with each other to avoid directional control problems.

That system had a backup high-pressure air bottle to hold the reverse ejectors in the extended position, and replaced the hydraulic pressure in the event of hydraulic failure. A lever on the pilot’s pedestal adjacent to the power levers activated that air bottle. Its only function was in case of hydraulic system failure. But this crew didn’t understand the function of that lever that was in plain sight.

During the approach, the crew actuated the switches necessary to extend the reverse ejectors. Residual hydraulic pressure and the flight air loads moved the ejectors into the reverse position. However, the air loads would quickly cease to exist after touchdown, making it urgent that the air bottle be actuated before landing. If this isn’t done, the reverse system could be expected to malfunction with dangerous directional control problems.

As the DC-8 continued toward the landing runway, neither the captain, the copilot, nor the flight engineer, knew the reverse system well enough to realize the necessity for actuating the high-pressure air supply for the reverse system, even though it was on the checklist.

Flight 859 touched down on Stapleton’s 26-left runway, its speed close to 140 miles per hour. Initially, the landing looked normal, and the emergency appeared to be over. The aircraft settled onto the runway, and proceeded straight ahead for the first thousand feet. But multiple problems were working against what should have been an uneventful landing.

Friends and relatives in the terminal watched the landing, and felt relieved as Flight 859 touched down in a seemingly normal manner. Fears subsided, but only for a few seconds. Also watching the arrival of flight 859 were FAA personnel from the Denver office, and United Airlines
training center personnel, all of who were responsible for what would shortly occur.

The captain made the landing. Straight ahead for a thousand feet went the DC-8, until the copilot applied reverse thrust. As could be expected, the two reverse ejector systems on the left side of the aircraft slid out of the reverse position, while the two reverse systems on the opposite side remained in reverse. When this happened, two engines provided forward thrust while two engines on the opposite wing produced reverse thrust, holding that wing back.

Flight 859 veered to the right, toward the terminal building. It left the smooth runway surface and encountered obstacles alongside the runway. Fortunately there weren’t other planes on the parallel taxiways. But not so fortunate was a civil engineer eating his lunch in a panel truck. He froze with fright as the DC-8 roared toward him, crushing him and dragging him along under the sliding aircraft. The impact killed him. Flames and smoke rose from the accident scene. Less than a thousand yards away stood horrified families and friends who were unable to help.

Except for the civil engineer crushed under the aircraft, the crash was survivable. Everyone on board the aircraft was alive, and should have remained that way. But there were other problems repeatedly reported by the FAA inspectors that sealed the fate for many who would never leave the aircraft alive.

**Passenger Evacuation by Crew was Inadequate**

The evacuation of the passengers went poorly. The cockpit crew left the aircraft while many passengers were still inside the cabin. In the rear cabin section, an army officer stood up and shouted for everyone to sit down. This was the worst response in any aircraft accident where survival depends on getting out of the aircraft as fast as possible.

Seated in the first class forward cabin section, an Air Force captain rushed to the front passenger entrance door immediately behind the crew compartment, and opened it. He assisted with passenger evacuation from the forward cabin section. With his help, the evacuation from the forward first class compartment proceeded smoothly. Before long, everyone in this section was safely outside.

**Don’t Forget Those in Back!**

But behind a door separating the first class from the economy section, over 60 passengers crammed into the narrow 15-inch isle, trying to evacuate from the rear of the aircraft. Safety was only a short distance away, behind a light-swinging door at the center of the cabin. In their confused state, the passengers needed only a crewmember leading them through this doorway to safety. It would have been so easy to save everyone. But no cockpit crewmember provided this life-saving assistance. They were safely outside the aircraft, watching the tragedy unfold. Before long, it was too late.

Among those seated in the crowded cabin were little Jason Gale, Nancy Guyer, and her three frightened and crying daughters. Confused,
and without guidance, they sat in their seat waiting for the help that never came. It was a virtual free-for-all, the weakest least likely to survive.

As the flames and smoke spread, passengers screamed, and children cried, as the heat from the flames increased. The passengers had ten minutes after the plane came to a stop to get out of the aircraft. But no one led them to safety. Finally, it was too late to save them. They were cremated alive.

Outside the burning jetliner, fight manager Lee Sloan declared, “No more planes for me, I’m riding the rails!” Lee had been escorting Jason Gale to California. He rushed back and forth shouting, “Where’s Jason, where’s Jason? Is Jason all right?” Lee had failed to take Jason with him as he dashed from the burning jetliner.

The fierce heat caused those outside the aircraft to move away from the burning aircraft. Rescuers abandoned hope for those still inside. It was a terrible sight for Doctor Guyer; trapped inside the burning aircraft were his wife and three children.

**FAA Inspectors Also Abandoned the Passengers**

Several FAA inspectors were deadheading on the aircraft, and they also ran from the aircraft, leaving passengers behind. One thing that I noticed as an FAA inspector was the lack of experience and competency of most inspectors. Only a few had airline experience, and of those, only a few had the ability, or willingness, to recognize and report the safety problems.

**Procession of Blackened Bodies**

Grief stricken families and friends watched the sad procession of blackened and charred bodies removed from the aircraft. Rescuers removed entire families in this manner. The young woman from Berkeley would never teach again. Mrs. Shepherd of Davenport would not arrive at the funeral of her friend. Mr. McDonald and his daughter Susan shared their last vacation and a common death. Little Jason was found burned to death, still in his seat, near Nancy Guyer and her three daughters huddled together in a death embrace. Next morning a grief-stricken Dr. Guyer drove home alone, his world seemingly had come to an end.

Enmity erupted as the massive suffering and death affected people’s emotions and reasoning. They directed their anger at the crew, rather than at those primarily to blame; UAL and FAA officials, who knew by their misconduct that crashes would continue to occur.

**Sham Showing of Concern**

The FAA Administrator and NTSB accident investigators rushed to the accident scene. Robert Murphy, heading the accident investigation, expressed sympathy for the families of persons killed or injured. After the crash I had notified Murphy and others in the NTSB of the serious safety violations and problems, violations, and culture, responsible for the air disaster. The NTSB wrote back that the violations that I described did not affect safety! I would find over the years that attempting to report grave safety problems to people in government always resulted in ex-
cases for doing nothing. And today, this culture is everywhere in government offices.

United Airlines DC-8 Crash at Denver

After the investigation, the government accident report described the immediate causes of the crash that were obvious. But as I found to be standard practice, the NTSB omitted the corrupt behind-the-scene problems. The report described the crew’s obvious lack of knowledge concerning the aircraft systems. This reflected directly upon UAL’s training and check program, and the FAA’s oversight of the program. Referring to the lack of knowledge concerning the engine reverse thrust system, the report stated:

There is an emergency provision for extending the ejectors by use of the air bottle system. That system was not used. This allowed Nos. 1 and 2 engines to develop forward thrust while engines Nos. 3 and 4 engines were producing reverse thrust during power application.

The Denver crash was directly affected by withholding legally required training that was reported in the FAA and NTSB sequestered October 16, 1960 FAA report. The accident report omitted the many other FAA reports describing serious safety problems in United’s training program. This relationship was again covered up by the NTSB, constituting a second falsified accident report. As previously stated, altering government reports, to convey an incorrect conclusion, or to avoid learning the truth, is a criminal offense. Followed by deaths, they are capital offenses.

8 Title 18 U.S.C. §§ 1001, 2071, 35.
“United has been doing this for years; they won’t change now.”

Shortly before this Denver crash, an FAA inspector on the same runway sat through a harrowing landing where directional control problems arose from United’s reverse procedure. Understandably upset, the inspector complained to FAA management, urging that this dangerous procedure be changed to that in use elsewhere. FAA Supervising Inspector Dave Haley replied, “United has been doing this for years; they won’t change now.”

The Federal Aviation Act and internal FAA directives give the FAA the power and the duty to act on safety problems. But the desire by government officials to placate influential airlines and manufacturers, to ingratiate themselves to the companies with whom they often seek post-government employment, and pressure from members of Congress, obstructs the government’s air safety functions.

UAL had other mishaps with the reverse procedure. Before volunteering for the United Airlines assignment, I investigated one incident that occurred at a central California airport. I was new with the FAA, unaware of the other FAA reports concerning United’s reverse procedure. I identified the reverse procedure as the probable cause of the incident, described it as hazardous, and recommended that the FAA order it stopped.

Eventually, the FAA requested, rather than ordered, UAL to change the reverse procedure. Although the responsibility and authority already existed, a specific Washington directive intended solely for United, known as ODCM 61-26, stated in part:

*We are of the opinion that the pilot who is physically controlling the airplane should operate reverse thrust or reverse propeller pitch thrust, as appropriate, on all landings and aborted takeoffs. This practice permits the pilot in control of the airplane to feel or sense any asymmetric conditions the instant it develops. Corrective action can then be applied by the pilot well before the asymmetrical conditions develops to the point that it is even recognizable by the pilot not in control of the aircraft...the air carrier shall be requested to revise its procedure.*

UAL management complied with this request; it didn’t cost anything. Changing the training program, however, required increasing training costs, and this was not done.

**Given the Assignment To Correct the Conditions Causing the Worst Series Of Airline Crashes in the Nation’s History**

I had been an FAA air carrier operations inspector in the Los Angeles office while the early United Airlines crashes were occurring. These crashes exceeded the total of all other airlines combined. I had been working with such airlines as American and Western and found their attitude and culture relating to operational safety to be very satisfactory. One day in 1963 FAA management personnel came to me and asked me to

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9 A mishap occurring during a landing at Visalia Airport in 1962.
accept an assignment to Denver, where most of United Airlines training was performed, and correct the conditions resulting in the senseless and preventable crashes.

One of these people requesting my transfer was Wurtley Rudd, a long-time dedicated FAA inspector who had conducted check rides of me on the North Atlantic while I was a captain for Transocean Airlines during the 1950s.

I was told that serious problems existed at United Airlines and in the Denver FAA office, but that the FAA would be fully behind me. It was already widely known throughout the FAA of these problems. I would learn that the first part of that statement was true, but the FAA support would be far behind me, or no support!

Upon transfer to Denver, where United Airlines did its training, I discovered that the United Airline crews still were not trained in the reverse system, even though ignorance of the system had already contributed to the deaths of many people. I tried to correct this lack of knowledge during flight and ground training and checks, but one inspector conveying information on a one-to-one basis could not get the job done.

Several years after the Denver crash, while walking by the crash site with United’s vice-president of flying, Gus Sommermeyer, he voiced objection to my efforts to make the crews aware of the reverse problem. Sommermeyer stated that United did not want me, an FAA inspector, covering any aircraft system or procedure that UAL management did not include in their training program.

This was a typical attitude of UAL management. By law it is the FAA’s responsibility to make the determination of what flight crews must know. Here was a United Airlines official telling an FAA inspector what the government inspector could and could not cover as part of his official FAA safety duties! I reminded Sommermeyer that it was the FAA’s function to insure that the crews have a proper knowledge of the aircraft and procedures, and reminded him of the tragedies arising from ignorance in this same area.

This Denver crash became a classic because of the senseless deaths. It was the catalyst for the most strongly worded government safety requirement ever written: a report that equated noncompliance with passenger deaths. The directive required emergency evacuation training of the crewmembers on a yearly basis, and described in detail what had to be done during this training. The intention was to prevent a repeat loss of life as occurred at Denver. The report stated in part:

**Passenger survival in actual emergencies is**

**Directly related to the adequacy of crew training**

The recent tragic loss of life in survivable air carrier accidents has focused the attention of all responsible segments of government and industry, as well as congress and the general public, on the problems of emergency evacuation, and dramatically underscores the extreme importance of timely and aggressive actions.
It is apparent from these studies that the chance of successful evacuation and passenger survival in actual emergencies is directly related to the adequacy of crew training...The Civil Air Regulations require initial and recurrent training in emergency procedures for all crewmembers...to the satisfaction of the Administrator. It is necessary that immediate actions be taken to insure that such demonstration is accomplished. I am sure you recognize the urgency of the situation and the extreme importance of the procedure outlined above.

Nine months after the Denver crash, UAL management continued to violate this federal air safety requirement continued to exist. The FAA Washington headquarters issued operations directive number ODCM 62-11, again stressing the need for the airlines to comply with this life-saving requirement:

A number of survivable accidents have occurred in recent years that have resulted in fatalities due to suffocation or burns. In addition, several incidents and accidents have occurred in which evacuation of passengers was impeded to such an extent that only the absence of fire, or success in controlling it, prevented serious injuries or loss of life. It is apparent from these studies and reports that passengers on all types of aircraft can be better prepared for survival by improved crew training and passenger briefing.

Despite the urgency of the training, an FAA internal directive (ODCM 63-4), dated almost a year after the two previous directives, found it again necessary to stress the importance of compliance:

The subject of emergency crew training has been of serious concern to the Administrator and Flight Standards Service for many months. Its importance has been stressed and emphasized during meetings, discussions and by correspondence to the field. ...it is evident that some carriers still are not complying.

There was still another FAA report released three years after the Denver crash, titled “Human Factors of Emergency Evacuation:”

Passengers can rapidly evacuate an aircraft...if the crew acts efficiently ... Any delays can be fatal ... Crew knowledge and effective leadership are the most significant factors identified in producing successful escapes. The larger the number of passengers, the more important is the role of the crew ... All of the crewmembers must [have adequate training]. Passengers look to and expect instructions and guidance from the professional crew... Efficiency of training should enhance confidence and ability to assess any emergency and be alert for the unexpected; which usually occurs, and take alternate courses of action for a successful emergency evacuation.

“Emergency crew training was ignored.”

In one FAA report describing the findings of a Washington inspection team, the continued noncompliance was indicated:
Prompt corrective actions not taken [by FAA] on deficiencies ... Amendments to comply with the Administrator’s actions of March and April ... and ODCM 62-11 regarding emergency crew training were ignored.

A later document revealing non-compliance:
Review of CAB accident report data showed that a large number of passengers involved in survivable accidents survived the crash impact but died as a result of asphyxiation because they were unable to evacuate the airplane. During the period ... there were four survivable air carrier accidents with 106 fatalities and 137 survivors. The record indicated that additional people could have survived if the passengers had been properly briefed or directed in the emergency evacuation of the airplane. The Agency believes that the conduct of emergency procedures is a problem of adequate crew training.

Obviously certain airlines were still violating this life saving requirement with the assistance of the local FAA offices. The Air Line Pilots Association recognized the importance of emergency evacuation training, and in an *Air Line Pilot* magazine article stated:

*Emergency training for all crewmembers is important and if it were to be summarized in one word, quality would be the most outstanding factor, which is generally lacking. If all the air carriers adopt high standards in developing their training programs in line with FAA requirements and if everyone worked on these procedures in a completely conscientious manner, there would be considerable improvement in this area.*

*The need for passenger assistance, which is a life-saving procedure, is a most important aspect, which becomes more critical as the passenger density increases. Accordingly, it is incumbent on the aviation industry to provide the air traveling public with a reasonable probability of survival recognizing that properly trained flight attendants are most important to successful evacuation and other emergencies, which arise in the cabin.*

Throughout the history of commercial aviation are scores of accounts of persons living through the actual crash of an airliner only to die because fire spread too quickly. They died because they were trapped inside the cabin...and for other needless reasons ... studies of air carrier accidents ... clearly indicate that too many lives have been lost in accidents which could be categorized as survivable.

**Non-Compliance Continued at United Airlines!**

Despite all these directives, despite the deadly consequences, non-compliance with the emergency evacuation training requirements continued at United Airlines. This noncompliance by United Airlines at its Denver training base, where the prior crash occurred that brought about this training requirement, was irresponsible. After arriving at United’s Denver training center, I discovered that UAL management was violating the emergency evacuation-training requirement. I reported this fact in
writing, stating that instead of accomplishing the legally required training once a year, the training was given only every three years, and then only in part. I reported that UAL personnel were falsifying records to indicate that the training had been given when in fact it had not been given.

I reported that one of the training center instructors admitted to me that the training was not accomplished, but that he had to do what he was instructed to do by UAL management.

FAA management, instead of forcing UAL management to provide the legally required training, removed my three reports from the files and destroyed them. Those were criminal acts, and before long, many more UAL passengers would be cremated alive due to inadequate passenger evacuation.

My discover and reports showed that for a two-year period many of United’s crews were in noncompliance with the law and flying illegally. Although it wasn’t his responsibility, I reminded one of United’s instructors who taught this subject that the training did not comply with Federal requirements, either as to frequency of training or the training covered. My reports made reference to his admission of non-compliance, and that he had no choice but to do what he was told. Rather than force United Airlines officials to make immediate correction of the training program and bring back to the training center those crewmembers who were not legal because of non-compliance with the training requirements, FAA officials obstructed correction of this serious violation.

**Importance Of Training and Competency Checks**

The direct cause of most airline crashes was pilot error, and that was usually due to inadequate training and inadequate standards on the yearly-required competency checks. Inadequate training and anything-goes competency standards saved considerable money for United Airlines, and the people responsible for saving the airline money profited through desirable higher paying positions.

When the occasional resulting crash occurred, insurance paid for the loss of the aircraft, and in some cases the insurance payment would be greater than the value of the aircraft on the books.

These problems were known to the airline management and to the FAA. Most major airlines had a relatively good training program and adequate competency standards, although even these could use improvements. But at United Airlines there was a culture that continued for many years and was a primary cause for the many preventable crashes and deaths.

**Airline’s Responsibilities**

In theory and under law it is the air carrier’s responsibility to take immediate corrective actions when safety deficiencies are obvious or reported to them by the FAA. The Federal Aviation Act states:

*The Administrator shall give full consideration to the duty resting upon air carriers to perform their services with the highest possible degree of safety in the public interest...*
When an airline safety program is found deficient, Title 49 U.S.C. § 1429 authorizes and requires the FAA to order changes to be made. Good training practices and high competency standards increase the probability that crewmembers will react properly to an abnormality or emergency, rather than just the possibility of their doing so.

The FAA Determines the Level and Adequacy of Safety

By law, the FAA Washington staff sets standards for the field offices to meet, and the field offices have the lawful responsibility to enforce them. The Federal Aviation Act requires the Federal Aviation Administration “to promote safety of flight of civil aircraft in air commerce” by the issuance of standards, rules and regulations. 49 U.S.C. § 1421(a). Under 49 U.S.C. § 1425(b) the Administrator is also required to employ inspectors who shall advise and cooperate with air carriers in the inspection and maintenance of aircraft, aircraft engines, propellers, and appliances used in air transportation. To carry out these mandates the FAA developed the Systems Worthiness Analysis Program (SWAP), consisting of Washington-based investigators who go into the field and conduct investigations of airlines that are already under daily inspection by the local FAA offices.

The local FAA district and regional offices approve the training program. The FAA inspectors, trained and experienced in the aircraft, determine whether the government standards are maintained. In an environment where any crewmember’s lack of knowledge can have tragic consequences, a meaningful training program with high standards is essential for adequate safety levels.

The FAA is comprised of numerous departments or “fiefdoms.” There is the department that establishes the safety standards, and there is the department (Flight Standards) that has the duty to enforce these standards. Just like HUD, FDA, and other government agencies, there are those employees who try to carry out the specifics and the intent of the agency, and there are those who strive to block the efforts or take the easy path of doing nothing.

In government agencies there are many reasons for the breakdown in the checks and balances. There is the revolving door syndrome (where government employees protect their future employers who are violating the law. There are pressures blocking regulatory functions by members of the U.S. House and Senate (as in the savings and loan cover-up by the Keating-Five and many other members of the House and Senate). There is the internal FAA “pecking order,” where lower FAA personnel benefit by carrying out the wishes of higher FAA management. There are bribes in the form of outright money, gifts, or other perks.

NTSB Responsibilities

Another government air safety agency is the National Transportation Safety Board (NTSB), which has two primary functions: One is to investigate airline crashes, report the probable causes, and make recommendations to the FAA to prevent repetition. The second is to investigate air
safety problems and make recommendations to the FAA that will prevent similar crashes in the future.

The FAA has the authority and responsibility to put new safety rules into effect, and need not wait for the NTSB to make the recommendations. But the FAA almost never takes measures to correct safety problems, even though the FAA inspectors are usually the first to discover them.

Federal Aviation Regulations require that the airlines submit training programs to the FAA for approval:

\textit{Each certificate holder shall establish, obtain approval of and maintain a training program that meets the approval of the FAA Administrator, as represented by the FAA inspectors. Whenever the inspector finds that revisions to an approved training program are necessary for the continued adequacy of the program, the certificate holder shall, after notification by the Administrator, make any changes in the program found by the Administrator to be necessary.}

\textit{“Its approval should be withdrawn immediately.”}

Internal FAA safety directives are explicit in requiring the FAA field offices to take immediate corrective actions when an inspector discovers unsatisfactory standards. A typical directive reads:

\textit{At any time such a training course is found deficient in the quality of training provided or fails to meet the requirements of the regulations, its approval should be withdrawn immediately. Special emphasis should be placed on the continuing surveillance of air carrier training programs.}

Federal safety directives issued under authority of the Federal Aviation Act leave no doubt that it is the FAA inspectors who investigate, evaluate and report the suitability of the carrier’s training program; there are no other qualified people within the FAA. One such authority states:

\textit{The inspector approves or disapproves all aspects of flight crew training programs operated by air carriers after assuring full compliance with all regulatory and other safety requirements pertinent to training operations ... assures further training and/or initiates and implements necessary changes in training programs.}

\textit{Maintains close surveillance of ground and simulated flight training of flight crews and initiates immediate action to correct any deficiencies in such training ... immediately implements any training or type-rating requirements which he deems necessary to establish and maintain crew proficiency and meets the basic requirements of Federal Aviation Regulations.}

\textbf{Checking Crew Competency}

A key element of an adequate training program is the periodic checks conducted to determine if a crewmember’s performance is satisfactory, or if additional training is required to fly safely in airline operations. The FAA approved company training manual requires that captains receive

\footnote{FAR 121.411 and 40.290, among others.}
training and competency checks twice a year, and copilots once a year.

By law, the FAA determines the acceptable level of competency, and this is described in internal FAA manuals prepared in Washington. Because of inspector shortages, the FAA approves company check pilots to act in place of the FAA inspectors. The FAA inspectors periodically observe the performance of company check airmen to determine if they are meeting FAA standards. The only purpose of the FAA inspector’s presence on these check flights is for that purpose. If an FAA inspector is dissatisfied with the company check airman’s safety standards, his attitude, his cooperation, or credibility, the FAA inspector must, by internal FAA directives, report his findings, and FAA officials are required to revoke the company check airman authority.

Washington directives make it clear that the company check airman’s standards have an important effect upon safety. Also, if pilots know that the check flight requires them to perform to high standards, they will usually perform to those standards, and prepare themselves ahead of time to pass the competency checks. Among the many FAA directives is the following:

Factual data available on several recent incidents and accidents indicates a pattern of questionable pilot instrument approach competency. In view of the extremely serious safety implications of marginal or questionable performance in this highly critical operational area, we view these indications with considerable concern. The continued competency of the pilot to skillfully execute the instrument approach is an extremely important objective of the air carrier’s training and flight checking programs.

The FAA inspector or air carrier check airman must take a highly critical view of the performance which the pilot demonstrates during type rating or proficiency flight checks. Nothing short of complete professional competency is acceptable. The attitude of the air carrier, its check pilots, are of major importance.

Operational inspectors of this Agency will consider very carefully this training and checking phase of air carrier training programs and will be required to take prompt corrective actions where deficiencies are found.

Assigned inspectors should constantly review and monitor the activity of company check pilots. The inspectors’ review and evaluation of the tests given by company check pilots will determine the adequacy and effectiveness of check pilot’s performance.

Inspectors should evaluate adequacy of standards required by check pilots on pilot proficiency checks. Inspectors should determine his technical qualifications and his ability to assure the desired high standards. The effectiveness of the air carrier’s training program is based on the performance of its check pilots.

However, what is required by law is openly violated at some favored airlines.
Inability of Safety Inspectors to Carry Out Government’s Air Safety Responsibilities

One of many internal FAA reports prepared by Washington inspection teams referred to the refusal by FAA management to act on safety violations or safety problems reported by FAA inspectors. This was especially noticeable at United Airlines, and a topic of conversation throughout the FAA. The report stated in part:

*Denver FAA inspectors are attempting to correct noted deficiencies in UAL’s training program ... The reaction of UAL [to the FAA training program requirements] appears to be in the form of resistance and resentment to these policies ... United Air Line’s complaints against Inspector Harrell are a manifestation of their basic disagreement and attitude with existing pilot training and certification requirements as required by the FAA."

A subsequent report, preceding the New York City and Denver crashes, showed the air safety problems still existing:

*UAL’s training program and their attitude toward FAA were discussed at length during discussion with the Denver ACSDO personnel. The [training] maneuver items ... are required by [law] and are presently recognized and administered as accepted procedures and standards by other air carriers ...

*The need for compliance with federal and industry accepted practices was brought to the attention of UAL on several occasions by inspectors ...[and] when after a reasonable time, flight checks showed that corrective actions had not been taken, UAL [was again told] that the CAMS [federal safety laws] must be followed and that the flight checks be conducted according to national standards.

*Inspectors are attempting to correct noted deficiencies in UAL’s training program.*

Chuck Stacy prepared that report of safety problems, and his obstruction to corrective actions appears in later pages.

Threats Against Inspectors Have Deadly Consequences

Within a month of my assignment to United Airlines, I discovered the same continuing problems. In one instance UAL check airman Bill Learned threatened me after I observed a serious safety problem and had tried to carry out the FAA’s safety responsibilities. Learned warned: “We got rid of Harrell and we’ll get rid of you if you continue this way.”

I had just observed Learned complete three flight checks of senior UAL captains and had never in my entire piloting career seen such dangerous performance by pilots. Learned wanted to pass all three pilots following the flight checks, despite the urgent need for corrective training and a recheck of their competency. The only reason I was present was to carry out the FAA’s responsibility to insure that the company check airmen approved by the FAA met FAA standards. Learned certainly didn’t meet those standards.

I tried to reason with Learned, and told him that if I were UAL’s
chief pilot and not an FAA inspector, my actions would be the same. I explained that United Airline’s “anything-goes” safety standards actually reduced the competency levels of many crewmembers, and that they could perform better if only the check airmen demanded better performance.

I reported that incident, and the written report recommended that the company check airman’s FAA approval be rescinded, as required by FAA internal directives. Instead, the office Supervising Inspector Dave Haley, and Los Angeles regional officials, wanted to suspend me from the DC-8 program! That threat occurred several times thereafter, whenever I reported a serious safety problem at United Airlines. It was as if UAL management was running the FAA. There may have been more truth to that than met the eye. It is a felony under federal law to threaten a government investigator.11

The deplorable competency of the UAL check airmen was indicated by the amount of simulator time the UAL instructors gave them before they felt the captains were ready for a recheck. One captain had over thirty hours of simulator time, which is more than a piston pilot gets when transitioning to the jets and had never flown a jet before.

**Prompt Corrective Action**

A typical FAA directive stressing the importance of record inspections stated: “Special emphasis should be placed on the continuing surveillance of air carrier training programs” by FAA inspectors, with prompt corrective actions for suspected deficiencies or irregularities.

The findings in the FAA record inspection at San Francisco, just prior to the New York City crash, where the inspection revealed felony falsification of training requirements, made the importance of record inspections especially urgent. And particularly at United Airlines. Shortly after joining the FAA, and shortly after the New York City and Denver disasters occurred, two FAA inspectors told me of their experience when they arrived at United’s Los Angeles offices to make a mandatory record inspection. A United official ordered them off the airline’s properties, refusing to allow the inspectors to inspect the crew records. This was a serious violation of the government’s air safety requirements, made more so by the two recent air tragedies, and especially by the findings of record falsifications.

FAA management in the Los Angeles Western Regional office, and primarily Lynn Ashwell, Chief of the Air Carrier Branch, criticized the inspectors for causing problems, and warned the inspectors not to make another try. FAA officials knew of the record inspection scandal just prior to the New York City and Denver crashes. They knew of the consequences in the two recent crashes. The FAA officials knew that the same misconduct continued, with the probability of future tragedies. Instead of ordering immediate corrective action, the report was removed from the files and actions taken to eventually bring about my removal.

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11 Title 18 U.S.C. § 111.
Inspectors eventually satisfied themselves with innocuous data inspections, such as date of birth, date of the required checks and other minutiae, and avoided a meaningful analysis of what the records sometimes reflected. The UAL and FAA coalition was a classic case of industry controlling the regulatory agency empowered to safeguard the public’s safety. And the public paid in gory air tragedies.

**Another Record Inspection Refusal**

Just as Harrell and other inspectors suspected training irregularities when they conducted the unexpected crosscheck of training records with aircraft logs, I also recognized the same problems. Seeking to further support my suspicions, I arrived at United Airline’s Denver training center to conduct a record inspection, as required by my job duties and FAA regulations. UAL management allowed me initial access to the records. But when I became suspicious of irregularities, and asked for related training records, UAL refused to allow the inspection, even though the records were present.

I reminded United that the law required them to produce the records for an inspection. They persisted in their refusal. They were hiding something. I returned to the FAA office, and filed a report of the violation, which stated in part:

*Upon analysis of the information obtained from [UAL], this inspector realized the relationship between failures and those that failed [only] when an inspector was on board. It appeared that possibly the only failures, except for possibly one or two exceptions, were [when] this inspector, or others, were on board. UAL personnel made certain records available, but refused to allow this inspector to obtain other information pertinent to, and necessary for a proper evaluation of the training center records and procedures. The information requested, available on the desk in front of this inspector, was refused.*

At that time, I was unaware of the explosive record inspection findings preceding the New York City crash. But FAA management was fully aware of the earlier report and findings, and of the tragic consequences at New York City and Denver. FAA management’s response to my report was predictable: they removed my report from the files, and barred me from making another record inspection. The records went uninspected. When I discovered the inspection report missing, I entered a copy of the original report. This further angered FAA management.

**Reporting Problems to Regional FAA Management**

During a Los Angeles regional office meeting with Chief of the Air Carrier Division, Al Butler, I reminded Butler of this serious and unlawful record inspection refusal, and the FAA’s negative reaction. I did not know at that time of the October 16, 1960, sequestered report. Butler knew of it; he was part of the inspection team that made the discovery. Butler didn’t volunteer any information on the earlier inspection and alarming findings. Butler sympathized with me, explaining that he knew of the problems at United and that he experienced the problems himself.
when he was assigned to the program. But he ignored his responsibilities, and did nothing. Higher officials controlled the hands-off policy.

“United has just crashed”!

During this meeting on December 30, 1964, while I was talking to Butler, an FAA employee rushed in and said, “A United plane has just crashed near Saugus!” This was a hillside community between Los Angeles and Bakersfield on the Grapevine route along Interstate 5. The pilots mismanaged the fuel supply, causing the two engines to run out of fuel, even though fuel for several hours of flight was still on board. Fortunately no one was killed in the crash.

**Fraudulent Inspection Reports**

Doctoring of inspection reports to make political powerful airlines look good was another problem within the FAA. A Los Angeles-based inspector visiting the Denver FAA office complained that FAA officials ordered him to delete safety irregularities in the report following a Blue Ribbon Inspection of a Seattle air carrier. Initially included in that report, but later deleted, were important training program irregularities. Ironically, that same air carrier had just experienced a crash into the Great Salt Lake during a training flight, with the death of all on board, including an FAA inspector.

Removal of official reports was another problem to cover up for safety violations. Ed Jensen, Principal Operations Inspector for Los Angeles Airways, described to me the illegal removal of two reports describing serious maintenance violations at that helicopter airline. Lynn Ashwell, Chief of the Air Carrier Branch, reportedly removed the reports from the files, and gave them back to Jensen, stating, “We don’t want these reports in the files.”

**Children Who Perished Would Probably be Alive Today**

Jensen said he still had the reports that Ashwell returned to him and, if the opportunity ever arose, he would gladly tell his story. I thought of this conversation after Los Angeles Airways experienced two fatal crashes near Disneyland; one on May 22, and the other on August 14, 1968, killing many children in each mishap. The NTSB blamed these accidents on faulty maintenance practices, and omitted reporting the felonious removal of pre-accident reports of the same problems.

**Removing Official Documents is a Crime**

Removing official government documents from government files violates several Federal criminal statutes, including section 2071 of Title 18 of the United States criminal code:

*Whoever willfully and unlawfully conceals, removes ... any record ... shall be fined not more than $2000, or imprisoned.*

**Very Few to Carry the Message**

Numerous safety articles stress the importance of good standards. But the political blocks, the covert back-room deals, the corruption, obstruct needed safety requirements from being addressed. Some airlines are not going to stress something that will raise their costs.
“The real need of civil aviation today,” stated Jeremiah Dempsey, former President of the International Air Transport Association, “is not, in my opinion, supersonic transport, but the establishment of a better safety record at a cost that will still leave air travel accessible.”

Speaking at a Flight Safety Foundation International Safety Seminar at Williamsburg, Virginia, Dempsey continued:

*There is, I believe, among the airlines a keen awareness of the need for raising the proficiency of their own people so that the human factor, insofar as it cannot be eliminated, may be raised to a standard that will provide the best attainable safeguards against human frailties which can play so fateful a part in times of crisis ... the solution of the urgent safety problems.*

**The Suffering That Accompanies Air Disasters**

“Civil aviation has no greater problem today,” Dempsey continued, “than the problem of safety. The suffering that accompanies air disasters leaves a deep impression on people’s minds ... any complacency in the effort to reduce it would not only be morally wrong and socially indefensible, it would be economically fatal to the advancement of commercial aviation.” But the continued disregard of safety problems makes it obvious that such statements are only rhetoric, often ignored.

**Destruction of Official Air Safety Reports**

A typical example of covering up the real cause of crashes and near-crashes surfaced when FAA management (Supervising Inspector Dave Haley, Denver office) wanted me to destroy my report of an engine flameout on a UAL DC-8 when the engineer made an error. I prepared a report describing the incident. But instead of recommending that the engineer be punished, I placed the blame on UAL’s flight engineer training program and the low standards. Office Supervising Inspector Dave Haley ordered me to withdraw the report and prepare another one, omitting reference to UAL’s training program. He wanted me to file a violation against the flight engineer, who was one of the victims of the training program fiasco. This required falsifying the report, which I refused to do.

My official report was illegally removed from the government files and the FAA charged the engineer (George Small) with violating federal air regulations, forcing him to pay a fine. FAA legal counsel accused the engineer of using poor judgment in analyzing the system abnormality, ignoring the fact that the engineer’s analysis of the problem was incorrect because of known inadequate training. By filing a violation report against the engineer, the FAA could show it took corrective action.

UAL crewmembers frequently confided to me that inflight emergencies or irregularities often occur but are not reported to the FAA so as to avoid license suspensions or fines.

One problem that did get reported was an incident involving malfunction of the pressurization system in a DC-8 cruising at 33,000 feet near Denver. Loss of automatic pressurization is no great problem if the manual backup system is correctly used. But in this case it wasn’t be-
cause the flight engineer and the pilots did not understand its use. This resulted in passengers threatened with a lack of oxygen, which could result in brain damage in a very short period of time. The captain made an emergency descent through altitudes assigned to other aircraft. That was a justified risk that should not have been necessary if the training was adequate.

I investigated this incident and discovered that the flight engineer had been trained and checked by a company pilot who was not qualified as an engineer, and under conditions that blocked the engineer from being checked and trained. Obviously, a check airman who doesn’t know the systems, who isn’t qualified, can’t be expected to train and check another crewmember for adequacy of knowledge. I recommended that the FAA require that a qualified flight engineer check the competency of the engineers, and supported my report with statements of United crewmembers who themselves admitted to the inadequacy. FAA officials ignored the recommendations.

“Crew Concept,” United Airlines’ Fancy Label to Reduce Training Costs

The poor training resulted in a serious lack of knowledge of aircraft systems, wherein many crewmembers lacked the knowledge to safely handle a system abnormality or emergency. UAL management cleverly got around this problem by giving it a fancy label: crew concept. Using this fancy label, UAL conducted competency checks permitting all three crewmembers to huddle together and try to come up with the answer that all three of them should have individually known without hesitation.

The mechanics of the crew-concept procedure were asinine. During checks of the crewmembers’ competency, a question would be asked of a crewmember as to what action to take for a particular abnormality or emergency. One crewmember would hesitantly come up with one guess. Another would add something to that. The third would also do so. Often the comments were wrong. Often none of the crewmembers knew the correct procedure that they each should have fully known.

The result was that when confronted with an emergency or abnormality, no one knew the correct procedure, all guessed at what should be done, and chaos occurred. This lack of knowledge repeatedly surfaced in crashes with heavy death tolls. Still, UAL management personnel stuck to their money-saving crew-concept strategy, and the crewmembers themselves bought it hook, line, and sinker. Preventable fatal crashes continued to occur for years thereafter.

At other airlines, and in the military, each crewmember had to pass a test of their knowledge without asking others for the answers. It was like taking a test of one’s knowledge and taking the instructor or someone else along to answer the questions.

The knowledge by other crewmembers of the correct procedures provides greater assurance that if the captain’s actions are incorrect, other crewmembers can promptly alert him to this fact. The speed with which
in-flight emergencies must be solved does not permit three inadequately 
trained crewmembers to pool their knowledge, and hope that the final 
decision does not rest on false assumptions.

Jet-Upset

Lack of training led to other problems. High altitude jet upset was 
one of them. A jet upset is a loss of control at high altitude, with the air-
craft falling out of control through many thousands of feet, with the dan-
ger that control would never be regained. Usually, as the higher density 
air is reached closer to the ground, the flight controls permit recovery, 	en often under spectacularly near-fatal circumstances.

A classic jet upset that I investigated occurred on a UAL Boeing 720 
enroute from San Francisco to Chicago on July 12, 1963. Cruising at 
37,000 feet, the captain decided to climb above cloud buildups, rather 
than fly around them. Proper training would have shown that the aircraft 
could not fly at the higher altitude for the existing weight and expected 
turbulence conditions. UAL Flight 746 commenced climbing to 41,000 
feet, an altitude that it never reached.

A phenomenon of high altitude operations is that the higher an air-
craft flies, at a given weight, the higher becomes the stalling speed at 
which the aircraft literally falls out of the air. The only data available to 
the pilots was a small and totally inadequate chart, when other informa-
tion was available that was not provided to the crewmembers. If that pi-
lot had the other information he would not have tried climbing to 41,000 
feet.

The pilots turned on the seat-belt sign and none too soon. As the air-
craft climbed, it encountered turbulence, which decreased the margin 
above the stall. Suddenly, the nose of the airplane pitched up beyond 
sixty degrees, seemingly straight up, and then the aircraft plunged nose-
down in a terrifying dive toward the ground. The rate of descent ex-
ceeded 21,000 feet per minute. The captain tried to move the elevators 
and the horizontal stabilizer but they wouldn’t move.

The high gravity or “G” forces made it difficult for the crew to reach 
for various control levers. Fortunately, as jet descended to lower altitudes 
where the air density was greater, the plane was finally brought under 
control at 14,000 feet. If it hadn’t been, a huge crater in the ground would 
have shortly occurred. The aircraft lost over twenty five thousand feet 
before it recovered from the jet upset.

Following this upset the FAA issued its usual order for all inspectors 
to insure that the air carriers provide adequate high altitude training to 
the crews. Inspectors hadn’t been able to obtain compliance with previ-
ous FAA directives or training shortcomings and it was unlikely UAL 
managers would respond to a new request. Further, there wasn’t much 
technical information available to the pilots, except the warning, don’t 
fly too high. But “too-high” means different things under different 
weight, turbulence, and maneuvering conditions. There weren’t any hard 
rules for avoiding jet upset. I was as ignorant as anyone else about the
problem; my jet training was the same as other airline pilots received.

The FAA gave me the assignment to investigate the mishap and making recommendations to prevent a recurrence. I studied the airline manuals, and didn’t find enough information for the pilots to intelligently address the problem. I obtained manufacturer manuals and examined various flight-test data. From this data I came up with a program that gave the pilots hard figures from which they could determine the maximum altitude to which they could climb under a given weight condition, angle of bank, and estimated “G” load increase from anticipated turbulence. I prepared a chart, with examples, and a training pamphlet, which I promoted at UAL and elsewhere.

Encouraged by good pilot acceptance, I submitted verbal and written recommendations to UAL and to the FAA, which included a chart and instructions. UAL management refused to change its training program, which then resulted in the crewmembers unable to answer questions concerning high altitude jet upset avoidance. Being unable to answer these basic questions, the pilots were unable to comply with the latest Washington directive.

FAA management, instead of ordering UAL to provide the required training, avoided a confrontation by ordering me to discontinue efforts in this area and not to ask UAL pilots questions concerning jet upset avoidance. United continued to experience upsets. In one mishap, a jet plunged from 37,000 to 29,000 feet over central Wyoming. Although the aircraft did not crash, one passenger, George Graves of Glenview, Illinois, died of the injuries he sustained in that incident.

Jerome Lederer, Technical Director of Flight Safety Foundation at that time, was quoted in Business and Commercial Aviation as blaming the occurrence of high altitude jet upsets on lack of training. Referring to another air safety problem, Lederer stated there was a strong need for effective check flights to detect and correct the “departure from good practice habitually and unwittingly made by pilots.” Lederer identified the barrier to adequate check and training safeguards as the “very fine financial and personal arrangements between pilots and many companies [that] encourage the pilot to accept hazardous practices for fear of jeopardizing his relations with management.”

When I later went to work for Flying Tigers writing their training manual for the stretched DC-8, I incorporated this technique into it. Douglas Aircraft then incorporated the procedure into their stretched DC-8 flight manual. They also used some of my other techniques, sometimes word for word. The jet-upset training aid slowly became adopted by other airlines.

Unsafe Safety Pilot, Another Cost Reduction Scheme

Another cost-reduction problem in UAL’s training program was its method of training and checking the pilots and flight engineer. All air carriers and military organizations throughout the world, except United Airlines, utilized a check pilot to train and check individual pilots while
the flight engineer was simultaneously trained and checked by a separate and qualified check engineer. In this way the engineer could be given additional advanced training, and his competency properly evaluated.

United Airlines twisted this time-honored practice in a way that reduced the cost of training, deprived the flight engineer of training, prevented him from being checked, and covered up for obviously needed corrective training. It was also fraught with dangers.

UAL check airmen eliminated the check engineer and used a single check pilot to train and check the two pilots while simultaneously “training” and “checking” the flight engineer. To carry out this charade, the check pilot, who was also the safety pilot, sat in the observer’s seat rather than at one of the controls.

The instructor pilot check airman, who is also the safety pilot, normally sits at one of the pilot control seats during training and flight checks so that he can instantly take over if an emergency flight maneuver is mishandled, as they sometimes are. He must be instantly ready to block an unsafe reaction by the pilot being trained or checked, or take life-saving corrective actions. Under this arrangement, the UAL check pilot couldn’t possibly training and check the flight engineer. But on paper, that function was being accomplished.

Basically, the competency check of the flight engineer consisted of evaluating whether the plane made it back without the flight engineer mishandling the systems. This didn’t meet the criteria for industry accepted or FAA required training and competency check of the flight engineers. Unable to check the engineer’s competency, it eliminated the need for additional training.

Offsetting this financial saving were the many near-accidents and the repeated fatal air tragedies. This threat to air safety and lives was obviously acceptable to UAL management and cooperating FAA officials. The conscientious inspectors expressed concern, but the FAA didn’t pay attention to them.

After one of these check flights I asked UAL check airman, Frank Cowles, with whom I could be candid, “Frank, you know you can’t possibly tell if that flight engineer you checked is competent, using United’s check procedures.”

“Unless he is real bad,” Cowles replied, “I can’t possibly make that determination.”

Other UAL crewmembers admitted the problem with poorly qualified flight engineers. Captains freely admitted they couldn’t trust their flight engineers because of the engineers’ lack of knowledge. The former flight engineer instructors and check airmen who were transferred to classroom duties, admitted the deterioration in engineer competency.

I included these admissions in my reports to show the dangerous nature of the method of training and checking and the greatly reduced competency levels that did not meet industry or FAA standards. No changes were made, despite the obvious danger.
Simulated Engine Failure

Before most of the training was done in simulators, a valuable training maneuver was to simulate an engine failure during takeoff immediately after the critical takeoff decision speed, called “V1.” UAL managers refused to do this maneuver, and refused to allow inspectors to perform it during flight checks, even though it was industry standard and required by the FAA. An earlier FAA report addressed this problem that was confined solely to United Airlines:

Engine failure (simulated during training and check flights) while the airplane is still on the ground is against UAL policy.

The FAA decides what safety maneuvers are to be demonstrated by a pilot before being licensed to fly the aircraft. It helps to insure competent piloting skills. Many near-crashes and actual crashes occurred following actual engine failure on takeoff, making training in that happening essential.

A tragic example of what can result from a real engine-failure malfunction came shortly after TWA flight 300 aborted a takeoff at Rome Airport. The captain rejected the takeoff when an engine malfunctioned. Before it was over, fifty-one people burned to death inside the aircraft. In another incident a Continental Airlines DC-10 rejected takeoff at Los Angeles Airport on March 1, 1978, there were fatalities. Obviously, training in this area is important.

When government inspectors requested the pilots to demonstrate this maneuver, UAL check airmen refused, stating, “Mr. Petty [senior vice-president, United] will not allow an engine to be simulated failed on the ground.” But the Federal Aviation Act legislated that the FAA will determine safety requirements and standards, not personnel at United Airlines, especially so, based upon the high accident rate at the airline.

Actually, an inspector’s protest over UAL’s refusal to allow simulation of engine failure on the ground was muted by a concern for his own life. Without a safety pilot at the flight controls to save the aircraft in the event of mishandling the aircraft during a simulated emergency, the inspectors didn’t push to have the required maneuver performed. A wrong rudder application, for instance, could result in the aircraft careening into buildings or the terminal alongside the runway, or create a serious yaw condition with possible loss of the aircraft.

The danger of the unsafe safety pilot could have been eliminated simply by forcing compliance with the federal laws, one of which (FAR amendment 40-21) stated:

In the interest of safety ... the check pilot [shall] occupy one of the pilot positions.

This directive was intended solely for United, as no other air carrier dared to engage in such folly. But as with so many other federal safety requirements, it was openly violated. Another federal directive (FS 8430.13) stated in part:

It is extremely important that the instructor or check pilot keep both
feet resting on the rudder pedals and be alert for possible use of the wrong rudder by the pilot [being trained or checked].

And still another federal directive stated:

*It is obvious that the preamble also recognized the safety question. It would appear, therefore, that the need for a qualified instructor or check pilot in the second seat during ground proximity and emergency maneuvers is obvious.*

This last directive was issued four years after the one previously cited, but United continued to ignore both of them. Another federal directive, again written because of the United Airlines practice, stated:

*A check pilot who occupies the observer’s seat, rather than the copilot position, is severely handicapped in giving a check by not being in a position to take over in an emergency. He is therefore usually disinclined to have an engine out on take-off or make 3 or 2 engine approaches, crosswind take-off or landing, etc. This interferes with the thoroughness of the check. We feel some urgency in UAL’s practice.*

No corrective action followed this urgent memorandum. Changing this procedure, forcing United Airlines to conduct their training and check flights as other airlines throughout the world conducted them, would have eliminated the large financial savings that had accrued from these practices.

Years earlier another FAA report described the problem. The report described UAL’s procedure of conducting flight checks in DC-8 aircraft “with two unrated applicants [students] occupying the two cockpit seats [simultaneously] during simulated emergency and instrument conditions.” This practice was *madness* and indicated the deep—seated problems at United Airlines.

**UAL Safety Pilot Jumping Out of Observer’s Seat**

It wasn’t unusual, and it was frightening, to see a UAL safety pilot *leap* out of the observer’s seat and frantically grab the power levers and control wheel to avoid a crash, while draped over the center console between the two pilots. The people in the houses below never realized what was going on over their heads. The danger was especially pronounced during simulated two-engine-inoperative approaches, during high-sinkrate approaches, during simulated engine failures, and especially when the pilot applied the wrong rudder.

The obvious danger was addressed in an FAA memorandum by FAA Flight Standards Chief William Krieger:

*There has existed a doubt concerning the safety of [this United practice] The [inspectors] in the Denver Air Carrier District Office have had several incidents in which this has created serious safety hazards ... In one case, which occurred last month during the conduct of a B-720 check, the aircraft sustained considerable damage from a landing out of such an approach ... The [safety] pilot was unable to take any direct action [because he was in the observer’s seat]*
The Airman Certification Specialists [inspectors] who have submitted comments are unanimous in their opinion [that this United practice is dangerous].

The FAA inspector, particularly in the DC-8, occupying the second observer’s seat, is unable to adequately observe the instruments during this period [to determine the performing pilot’s competency].

A few days later, in response to joint inspector pressure rarely seen within the FAA, Krieger signed a document stating: “UAL certainly should not be allowed to continue [this practice].”

But the unsafe practice continued. During sworn testimony two years later at a Denver air safety hearing (yet to be described), Krieger contradicted these statements, as he sought to protect United Airlines dangerous practices and excuse FAA for failure to act. This political aviation-ignorant FAA official testified at that hearing that the safety pilot sitting in the observer’s seat was not a dangerous procedure.

The Denver inspectors attempted to change the practice, but that fizzled. An FAA official wrote: “At 1919 MST this date, Mr. Ashwell called and advised that he had just received an urgent call from UAL. It was my understanding that UAL was quite upset relative to the changes we had requested, making reference to the requirement that the safety pilot be seated at the flight controls.” The memorandum continued: “It was our intent that a safety pilot be required on all flight proficiency-check maneuvers....” The latter reference was to UAL’s attempt to placate the inspectors’ protests by having the safety pilot at the flight controls only when inspectors were on board the aircraft.

I protested. The safety laws were not written to protect FAA inspectors! The danger continued to affect crewmembers and people on the ground. Another FAA report stated:

*The FAA must immediately take steps to have UAL utilize qualified safety pilots on proficiency checks...* [safety laws] *did not envision safety compromise in air carrier training and checks ... It would appear, therefore, that the need for a qualified instructor or check pilot in the second control seat during ground proximity and emergency maneuvers is obvious ... in the interest of safety, for the check pilots to occupy one of the pilot positions.*

*“It is dangerous, and should be discontinued.”*

A report signed by myself and five other FAA inspectors in the Denver office stated:

*The inspectors feel it is dangerous and should be discontinued. This was the opinion of all specialists in attendance. Stich related his observance of UAL safety pilots jumping out of the seat situated behind the Captain to take corrective action during pilot proficiency checks.*

In one report I wrote:

*The condition whereby the United Airlines’ check pilot jumps to his feet to take corrective action is not unusual. [The procedure] requires IMMEDIATE CORRECTIVE ACTION ... With the safety pilot
responsible for the [safety of the] aircraft, sitting in the jump seat, which is remotely located behind the pilot, it is obvious that corrective action is limited. This practice, safety wise, is unsatisfactory. The danger is very evident when one sits through such an episode ...

[This UAL practice] is fraught with hazards and could easily result in an aircraft, its crew, and an FAA inspector being lost. Add to this the occupants of the homes under the aircraft!

The warning of an impending accident was well timed. Ten days after the report was written, a UAL flight with an FAA inspector rode through a harrowing incident at Cheyenne, Wyoming. It started with poor piloting technique while the safety pilot, in the observer’s seat, checked the captain’s proficiency during simulated emergency maneuvers. Compounded by the absence of a safety pilot at the flight controls, things got out of control fast.

"Flare it! Flare it!"

The inspector riding through the Cheyenne incident stated in his official report:

After noticing the Captain’s performance in the simulator, I felt that the flight check should be observed by an FAA inspector. It became obvious that there was going to be a hard landing so I got into the second jump seat and held on to the bottom of the seat. At the same time I heard the check pilot shout, “Flare it, flare it!” and then we hit the runway...

The aircraft bounced back into the air approximately 50 feet and came down on its nose wheels and apparently blew one or both of the tires. [The captain] pulled back on the yoke and the aircraft became airborne again and it appeared to go higher and the angle of attack became more pronounced. The aircraft hit nose wheel first and bounced back into the air, higher than the preceding oscillation and back down in a steeper dive. The check pilot shouted, “Stop it! stop it! Pull the speed brake, reverse!”

The aircraft hit hard, but with the speed brakes extended, the aircraft failed to become airborne. I feel that had the aircraft made another oscillation, the aircraft would either land on its nose or back.

Inspectors Refused to Ride on UAL Check Flights

Many people could have been killed in their homes if this jet had crashed. This harrowing experience closely followed my written reports, and precipitated an unheard-of coordination among FAA inspectors. They refused to board any UAL training flight for the next few weeks. The FAA allowed United to continue the known dangerous practice, despite the threats to the crewmembers and the people on the ground.

“We value the lives of our crews higher than that.”

I discussed this practice with an Eastern Airlines official at Miami, who replied, “We value the lives of our crews higher than that.”

How bad can mishandling of the flight become? Aerospace Safety
reported a cockpit scene occurring during a flight check:

On final approach the student pilot inadvertently feathered one of the two engines. In the instant it took to analyze what had happened, the [instructor pilot] increased the power on the good engine. Thinking they were going around, the student retracted the gear.

The IP immediately ordered the gear lowered and the student got the flap handle instead [which placed the aircraft near the stall speed and possibly a crash condition]. Meanwhile, the IP told the engineer to bring the engine back in. Unfortunately, the engineer hit the wrong button and feathered the remaining engine. The IP put the gear down himself and made a successful landing, despite the confusion. Then to cap this incident, the engineer moved the gear lever to ‘Positive Lock’ and the gear collapsed on the runway.

Keystone Cop Routine?

Incredibly bad performance? Yes! But an inspector routinely sees various shades of this as part of his job. It isn’t comforting to know what goes on in the flight station with poorly trained or improperly checked crewmembers. The dangers involved in flight training don’t mean such training should be eliminated. On the contrary, the need for further training under carefully controlled conditions, with the safety pilot constantly alert to the need for immediate corrective actions, is important.

A brutal tragedy at New Orleans shows what can happen if a safety pilot is not alert (or if the safety pilot was not at the flight controls, as was the UAL practice). The consequences were shown by a Delta DC-8 that crashed into the Hilton Inn at New Orleans on March 30, 1967, during a late-night training flight. The New Orleans papers described the tragedy:

Nine high school girls from Juda, Wisconsin, were among the 18 persons killed in the flaming crash. Eight of the dead girls were found huddled together in a charred bathroom of the motel. The body of a ninth was blown outside. The surviving students, many hysterical or in a daze, were placed under sedation ... Police Captain Marvin Leonard stated: “There were eight girls in four rooms. You could see where they took refuge in the shower stalls. They turned on the water, but it didn’t do them any good.” Some charred rooms were inaccessible for hours because of the heat. The charred, decapitated body of a small boy was found in the remains of one home. A woman’s body was nearby.

These deaths did not result from the training as much as they resulted from two problems: One was conducting the training at midnight when alertness is greatly diminished. The second was the carelessness of the safety pilot (probably fatigue induced because of the midnight training) who allowed an unsafe handling of the aircraft to progress beyond normal limits. The pilot being checked had been making a simulated two-engine-out approach and had let the speed decrease below minimum control airspeed.
This tragedy also showed what can happen to those on the ground if a competent and alert safety pilot is not at the flight controls, or conducted at unsafe hours. Shortly before that crash occurred, I had finished recurrent training with Pan American with most of the training conducted after midnight. My report stated that late night training flights are dangerous. The pilots are not sharp enough to cope with simulated engine failures, no-flap landings, and other simulated emergencies.

**Danger of Aircraft Training Mostly Eliminated Today**

Today, most airline training and checks are done in the advanced simulators, virtually eliminating training that was formerly done in the aircraft.

**Leading Weak Crewmembers Through Competency Checks**

Another problem frequently encountered at UAL was the practice of company check airmen leading the crewmembers through the flight checks while the pilot’s competency was being checked. Instead of checking the pilot’s ability to handle the flight, we ended up checking the company check airman who literally took the check for the crewmember! It was similar to UAL’s crew-concept where others could answer the questions or perform the maneuver, masking the possible incompetency of the crewmembers being checked.

Without this help, the crewmembers could not pass the test, showing the need for corrective training. This unacceptable practice continued despite inspectors’ protests, and was the subject of an FAA letter years earlier:

*We cannot condone the [company check pilot] instructing or leading the applicant through the check.*

I frequently reported the problem, as did other inspectors. But FAA management refused to force a change, making it impossible to know if the pilot’s performance was satisfactory or not. I repeatedly objected to this, and repeatedly encountered confrontations. During one such confrontation at San Francisco with United Check Airman Dale Cavanaugh, I instructed him to let the applicant being checked perform the maneuver. When he refused to do this, I notified him the check could not continue.

**Take-Off Power, but Which Way Do the Power Levers Go?**

A seemingly small but dangerous practice that has resulted in crashes and caused changes in cockpit terminology, except at United, had to do with power application and removal. Occasionally, especially during very turbulent conditions, the captain who may have both hands on the control wheel during heavy turbulence may call for the power that he wants. UAL’s procedure for ordering the other pilot to advance the thrust levers to maximum allowable thrust was to command, “Take Off Power.” But did he want the power taken off, or did he want maximum rated power that is normally used for takeoff?

Accident investigations have shown that under stress conditions, especially close to the ground, the sudden command, “Take off power,” has frequently resulted in just that: the power taken off to idle thrust, when
the pilot calling for “take-off” power wanted maximum rated power.

If the power is taken off, such as when approaching the runway (and possibly over approach lights), when the captain wanted to make an emergency missed approach requiring maximum power, tragedy can result.

The term, “take-off power,” had been abandoned years earlier in all known flight operations; except, of course, at United Airlines. If maximum power is wanted, instead of calling, “Take Off Power,” the standard command now is to call, “Max Power.” The consequences of the take-off power command was seen during UAL training flights when the crew-member adjusting the power levers hesitated, not knowing whether the captain wanted the power taken off or full power added. The Airline Pilot Magazine made reference to the problem, stating:

There is the critical problem of the choice of words to be used. I think all of us have been exposed to, or have experienced “Take-off” power [command] and the power is taken off, when such response was certainly not wanted.

Prior to that ALPA article I prepared an FAA letter for transmittal to UAL, asking to get this confusing and dangerous terminology changed. It was, of course, the FAA’s responsibility to order the change because of the safety aspects. In my letter I described the problem with this confusing command; its replacement years ago by the military and other air carriers, its association with prior accidents, and the confusion seen at United by its use. I suggested changing the command to the standard, “Max Power.”

UAL’s Mr. Petty refused, writing back that the command would be confusing if a pilot by the name of “Max” was in the cockpit!

Other inspectors, and I frequently reported the deficient safety standards exhibited by UAL check airmen.

Other airlines knew that UAL managers manipulated FAA officials, and sometimes made reference to the problem. A typical example of undermining inspectors’ safety functions was the experience of FAA inspector Peter Chesney of the Denver FAA office during a confrontation with Continental Airlines. In this incident Chesney observed an unsatisfactory flight check performance by a Continental Airlines captain who the company check airman wanted to pass as satisfactory. Chesney reported the captain’s performance as unsatisfactory, requiring the captain to be taken off the schedule, given additional training, and a recheck.

Because of the company check airman’s poor standards and poor attitude, the inspector recommended that the FAA remove his authority to conduct check flights, as required by internal FAA directives. The inspector’s report became an official document and could not be legally removed and destroyed. But it was removed from the official records, and the Denver supervising inspector, Dave Haley, ordered the captain reinstated, without any training or recheck to address the safety problems.

The unsatisfactory report of the company check airman was also de-
stroked. In addition, the inspector was called back to the office on his day off, and admonished for making the report. I personally felt Haley was one of the most aviation-ignorant employees the FAA had, and that many accidents and deaths occurred because of his interference.

Before transferring to Denver, Haley had the safety responsibilities for several airlines in the Northeast, some of which experienced a series of fatal air tragedies that were related to poor training standards. The Northeast Region addressed the problem with Haley by the typical “up-and-out procedure.” Unwanted employees are promoted and transferred elsewhere. In this way an unwanted bureaucrat becomes someone else’s problem.

I had it even worse then Chesney and the other inspectors because UAL’s DC-8 program contained most of the senior pilots, and they were the most vocal in opposing the FAA role under the Federal Aviation Act. They wouldn’t accept the government’s safety role that came about following United’s ramming of TWA over the Grand Canyon.

A similar but far worse incident occurred within a month of my arrival at UAL’s Denver training base. As part of my official function, I witnessed the check flight performed by check airman Clarence Pratt. This FAA-approved company check airman was conducting the six-month competency flight check on two senior UAL pilots who were themselves check airmen. My report stated in part:

The conduct of the check ride by the pilots was definitely unsatisfactory; certain maneuvers being actually unsafe. The company check pilot did not find fault with the maneuvers during the flight, and indicated satisfactory performance, despite the fact that the unsatisfactory items were repeated time and again. Upon debriefing, the check pilot informed this inspector that he considered the flight portion of both pilots satisfactory, and he did not intend to repeat any of the items. This opinion persisted even when confronted with the written notes made during the unsatisfactory portion of the flight check.

My report detailed the dangerous flap mismanagement wherein the aircraft nearly stalled out during a missed approach at low altitude. Both pilots had poor directional control following simulated engine failures. In one instance the pilot lost 80 degrees of heading after a simulated engine failure (15 degrees was the approximate maximum allowable). The airspeed control was very poor and the deviation far exceeded tolerances. They had poor knowledge of the flight procedures.

They were actually dangerous. The flight was the poorest I had ever experienced during thirty-five years of piloting, and encompassing many airlines throughout the world. I couldn’t believe what I was seeing. These were the conditions that prior inspectors had repeatedly encountered, and went uncorrected, which caused the record number of fatal crashes and deaths of passengers at the airline. Unfortunately, this relationship is unknown except to a few insiders.

These three key company check airmen were responsible for setting
acceptable safety standards of other pilots, and setting comparable stan-
dards. These three company check airmen had a definite influence upon
the standards of line pilots, and helped explain the New York City and
Denver crashes, and the many others that occurred before that, and the
many others that followed. I finished my report by stating:
This inspector feels that the greatest detriment to bringing up the
standards of the pilots with UAL are the laxness and low standards
by certain of the flight standards check pilots. It is obvious to this in-
spector that many of the check pilots could increase their standards.

During the post-flight debriefing in UAL’s offices, the United check pilot
argued and insisted that the pilots should be passed, even after being con-
fronted with the specific performance shortcomings. I tried to reason
with the company check pilot, trying to convince him that additional
training would correct the problems. The check pilot would hear none of
this. United was on a roll, having successfully gotten rid of other inspec-
tors who interfered with their illegal and unsafe operations. He knew
FAA inspectors had no backing.

I reported the unsatisfactory company check airman performance,
and recommended removal of his FAA authorization, as required by FAA
internal directives. Changes were made; the next day Supervising Inspec-
tor Dave Haley advised me that I would probably be suspended from my
job assignment on the DC-8 program. Somehow I managed to escape
removal from the program. But other incidents kept occurring, prevent-
ing correction of the serious safety problems.

“You can’t argue with success.”

Things were never dull on the United DC-8 program, and as I look
back, I wonder how I survived such a mess. On another flight check that
I observed, the pilot crossed the approach end of the runway at a danger-
ously high speed; forty knots too fast. If the runway had been minimum
length for that particular weight, the aircraft would probably have
crashed off the far end of the runway. If there had been a motel or other
building at the end of the runway, our aircraft would probably have cre-
mated some of the people in the structures.

Part of the flight check is to determine safe speed control, and forty
knots too fast over the end of the runway isn’t satisfactory by a long shot.
Usually ten knots is the maximum acceptable excess (except during
gusty wind conditions). Rather than demand that the pilot repeat the per-
formance (and cost the airline additional money in performing the ma-
neuver, or risk retraining), the UAL check airman wanted to pass the pi-
lot.

The danger of landing too fast was revealed by a Southwest Airlines
Boeing 737 crashing through the fence and onto the heavily trafficked
road at the far end of the runway at Burbank Airport in Los Angeles in

**Better to Crash at the Far End of the Runway**

Again I tried to reason with the United Airline check pilot, Clarence
Pratt. Rather than demanding satisfactory performance, which the pilot being checked could probably have given if he knew he had to adhere to required standards, the company check airman defended the dangerous performance. “Better fast than slow,” Pratt argued. He meant it was better to crash at the far end of the runway due to excess speed, than to crash at the approach end with insufficient speed! But the purpose of the flight check was to insure the pilot could safely fly the aircraft, and not to check the best way to crash!

**Petty Office Politics With Incompetent FAA Inspectors**

Problems were all over. Another inspector and I discussed the scheduled flight check for a UAL captain from Chicago the next day that was known to be a weak pilot. I casually stated I intended to be on the flight to insure that some semblance of standards be applied. On the other side of the partition, another inspector, Ivan Behel, heard the conversation. He rushed to Supervising Inspector Dave Haley and repeated what I stated. Within an hour the Haley ordered me not to be on the flight. No inspector, no confrontation!

This incident was common of the petty office spy system, and showed the level of maturity with which the public’s lives were handled within the FAA. When I first arrived in the Denver Office, I was surprised when other inspectors motioned me outside the building to a secluded spot when we had to discuss a particular safety problem involving United Airlines. These old timers already knew the pettiness that existed, and didn’t want certain inspectors eavesdropping and then running to the supervisor trying to halt us from carrying out our safety responsibilities.

Behel was a former Air Force pilot and one of the worst tattle-tales in the Denver office, I often wondered if the Air Force conducted its internal affairs in this manner.

**Dangerous High Sink-Rate Approaches Were Common at UAL**

Another common problem at UAL was the practice of high-sink-rate approaches, wherein the aircraft was allowed to descend at a dangerously high sink rate toward the ground during final approach. Just before making ground contact the pilot pulled back on the control column to stop the high descent rate. The danger in that type of approach was that the aircraft might not respond and continue its downward path, hitting the ground (or a vertical seawall) short of the runway. If the approach speed was stabilized, as required, this danger was greatly reduced. If the pilot approached the runway at a higher speed, they got away with the high sink rate approaches. Both deviations were dangerous and unacceptable.

During an enroute check on United Airlines from Denver to Los Angeles, the captain made one of the worst high-sink-rate approaches that I had yet witnessed. It was the closest flight profile to a hot-rod Navy fighter plane approach. As the United pilot passed abeam of the downwind end of the Los Angeles runway, at 1500 feet, close to the landing runway, the captain pulled the power completely off, put the plane into a steep bank exceeding thirty degrees and the plane went down like a rock.
Just prior to touching down the pilot pulled back on the control column to stop the steep descent. Fortunately his uncoordinated and unapproved approach had extra speed that saved us from crashing into the ground. It was a dangerous and totally unacceptable approach.

After the pilots shut down the engines and completed the final checklist, I attempted to do the job the FAA paid me to do. I tactfully debriefed the flight crew, and explained the dangers of that type of approach. The captain reacted by lambasting me and implying I didn’t know what I was talking about.

The consequences of this attitude were made worse by the fact that the captain, Bart Stephens, was also an FAA-approved company check airman. In addition, he was one of the two captains I downgraded shortly after I arrived on the United Airlines assignment. This dangerous piloting technique and attitude required his removal from check-pilot status. He was responsible for preventing the same type of dangerous piloting performance of other pilots.

There was a funeral in Seattle several days later for an FAA inspector killed during a high-sink-rate descent during a training flight over the Great Salt Lake near Salt Lake City. Several senior ALPA members pressured the Chief of the FAA Air Carrier Operations Section, Lynn Ashwell, to remove me from the UAL assignment because of my comments to the Stephens at Los Angeles. Ashwell was noted for appeasing airline and pilot union officials.

The FAA then suspended me from the DC-8 program. Ironically, relief came about two weeks later from a UAL flight manager, Charley Skannal. While I was talking to Skannal in his Denver office on another matter, I mentioned to him that I had been removed from the DC-8 program. Skannal picked up the phone and called Ashwell, advising that my suspension had gone on long enough, and that I should be put back on the program. Ashwell complied. I felt Skannal was more conscientious than most of United managers. Shortly thereafter, Skannal was removed from his position.

I observed other high-sink-rate approaches at United Airlines that would have deadly consequences some months later. During an enroute check from Chicago to Denver, I observed and reported that the captain, Gale Kehmeier, had a high-sink-rate approach technique and needed corrective training. FAA supervising inspector Dave Haley refused to require the additional training. “He’s always been weak,” was the reply, and it seemingly ended there. But it didn’t end there. Forty three people would be cremated alive because of the same approach technique by the same captain.

The breakdown in normal relationships surfaced in many areas. On a United Airlines bulletin board in Denver I read a surly letter from a senior United Airlines captain, dissatisfied with constructive criticism of his apparently unsatisfactory flight check performance. The pilot lambasted and tried to ridicule the check airman who dared to make constructive
comments that would have benefited the pilot and his passengers and crew.

**The Same Problems on Enroute Flight Checks**

Inspectors conduct enroute checks on regular passenger flights, sitting behind the pilots, and evaluating their performance and their compliance with company and government requirements. Properly conducted without any harassment of the inspector, safety is improved.

One interesting enroute check that could easily have been fatal occurred around midnight during a low-visibility approach to San Francisco International Airport. As the captain maneuvered the aircraft on the Instrument Landing System (ILS) approach to the fog-shrouded runway, he drifted left of the centerline just as we approached minimum altitude of 200 feet. Neither the runway nor the approach lights were in sight. An immediate missed approach was required under safety and legal considerations. Suddenly the captain saw the glare of the approach and runway lights off to the right. He tried to maneuver, at less than 200 feet above the water, even though there was no horizon or any other feature to determine aircraft attitude.

"Take it around! Take it around! Take it around!"

A vertical seawall was immediately below us as the copilot shouted for the captain to execute a missed approach. The copilot was frantic. I was alarmed. I was about to shout, but the copilot beat me to it by a split second. "Take it around! Take it around! Take it around!"

A captain’s authority is rarely challenged. But in this case, it was a matter of life or death. At first, the captain hesitated, but then reluctantly moved the four power levers to max rated power position, and simultaneously raised the nose to stop the descent and get a positive rate of climb. But all wasn’t well. The captain suddenly experienced vertigo beyond his ability to handle it, and the copilot had to take control of the aircraft.

As we climbed out from that potentially catastrophic encounter, approach control cleared the flight for another ILS approach. The captain was still unable to handle the aircraft, and the copilot flew the approach. Fortunately, the copilot was heavy on experience and well qualified. The captain sat mute as the flight barely made it in before the fog closed down the airport behind us. The passengers never knew how close death had been. Statistically, it was a safe flight.

As the passengers left the aircraft, a problem remained. The crew was scheduled to take the plane back to Denver that night, with another load of passengers. As a government inspector, I had a decision to make. It was possible the captain had an illness, or simply needed more training in low-visibility approaches. If I grounded the crew, with possible cancellation of the flight, I would surely be removed from the program, and my effectiveness would end.

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12 Applying maximum rated power, rotating the nose upward and obtaining a positive rate of climb, and calling for the flaps to the takeoff setting.
I advised the crew to delay the flight until I cleared it with the Denver FAA office. I then called Hiram Broiles, the principal inspector for United Airlines, at his home, and explained the situation. I described the events, stated that I had no way of knowing what the captain’s problem was; if it was a one-time error that could have happened to any pilot; if he needed additional training; or if he was ill. I also advised that the captain should be rechecked before scheduled for another flight. The FAA official advised to let the captain fly the trip back. Fortunately, it went uneventful, as far as I know.

**Tragedy from a Similar Incident Nearby**

At another California airport at about the same time of night, a Flying Tiger plane crashed into a residential area during an instrument approach to Burbank Airport. Everyone on the plane perished as well as several people on the ground. The subsequent government accident report placed the probable cause on pilot incapacitation and the inadequate training of the copilot.

The problem could have been the same as I encountered at San Francisco, and a study of both crashes might have exposed problems not previously recognized. However, the system doesn’t work the way it should. Upon returning to the FAA Denver office several days later, even before I submitted the report on the San Francisco incident, FAA management criticized me. Their position was that if I had not been on the aircraft making an official enroute check, the problem would never have been known, and the FAA office tranquility would not be disturbed.

“If you don’t like the way we do things here, quit!”

I expressed puzzlement at this FAA criticism from Dave Haley, the office Supervising Inspector. He responded, “If you don’t like the way we do things here, quit!” Haley’s conduct, I feel certain, resulted in many deaths that could have been prevented if he had not blocked correction actions on known safety problems. Besides putting up with Haley, who I considered a dangerous idiot, I had to contend with the serious problems at United Airlines.

**Questioning FAA Inspectors Right to Judge UAL Pilots**

Things were never dull. A meeting between United and FAA officials occurred in United Airline’s Denver offices several days later. Frank Crismon, manager of United’s flight operations at Denver, started the meeting by sarcastically challenging my right, as a FAA inspector, to question the competency of their pilots. This was the typical attitude of United Airlines officials.

UAL management never did adjust to the Federal Aviation Act following their ramming of TWA over the Grand Canyon. They resented FAA inspectors carrying out the government’s air safety functions. This attitude was fostered by the collusion between FAA and United officials. If FAA officials had met their safety responsibilities, UAL managers would not have attempted many of the shenanigans they pulled.

I had the least FAA seniority of any of the FAA personnel present,
but by far the greatest amount of aviation expertise. The others sat mute, afraid to tangle with Crismon. I stated in no uncertain terms to Crismon, “It isn’t for United to question the authority of the FAA; that has been long established by law!” Crismon and I were in a heated debate until another UAL manager motioned Crismon to shut up.

Since Crismon raised the subject of my qualifications, I reminded Crismon that I had over 15,000 hours of pilot experience in diversified world-wide airline operations; that I held virtually every aircraft rating issued by the FAA; and that my experience probably exceeded that of most United Airlines pilots. Further, I reminded him that by law it is the inspector’s responsibilities to evaluate the capabilities of airline pilots. If I wasn’t qualified, with all this experience, the government’s air safety agency might as well shut down.

Crismon’s position was untenable, but mine was impossible, lacking the necessary backing. Crismon then admitted at the end of the meeting that the captain involved in the San Francisco incident had been examined by a company physician after the flight, and supposedly found to be ill and removed from flight schedule. Until then, Crismon refused to admit anything was wrong, and that I and the UAL copilot were at fault for questioning the captain’s performance. I later learned that the captain was grounded with a medical problem for over a year after that incident.

Many of UAL’s conscientious instructors and check airmen encountered similar problems. They would confide in me that if they downgraded crewmembers as weak and requiring additional training that UAL flight managers applied pressure to have them relax their standards. If pressure didn’t succeed, they were removed from check status.

One of my reports on the dismal standards of UAL check airmen read: “Questionable Adequacy of Flight Standards Check Airman, Mr. Dale Cavanaugh.” I described unacceptable standards that deprived crewmembers of training, the check airmen’s refusal to cooperate with the inspector’s participation in flight checks, and conduct destructive to the FAA’s safety functions. I recommended canceling his FAA authority.

For at least five years prior to my report, other inspectors reported the same problems with Cavanaugh. Never in the many years that inspectors made these reports did FAA officials ever remove FAA approval from a United Airlines check airman. Instead, FAA and United officials harassed and threatened FAA inspectors who made the recommendations. FAA Washington headquarters knew about the problems, and did nothing. The FAA Washington investigation teams reported the problems, but those responsible to correct them refused to do so. Shortly before my reports were made, a Washington inspection team wrote a damaging report, stating in part:

*The functions and responsibilities of the Flight Standards Division, its Air Carrier Branch and the Air Carrier District Offices are not being accomplished in accordance with the functional assignments and responsibilities.”*
In bland government language, the report stated that the FAA was not doing the safety function it was delegated to do by the Federal Aviation Act:

FAA actions appear to be in defense of the operator rather than being conducive to achieving a high level of safety. A philosophy that allows noncompliance with regulations is not consistent with the philosophy of promoting the safety of flight ... Most supervisory levels in the air carrier programs do not indicate an awareness of their responsibility to control and evaluate their assigned programs ... Long standing deficiencies continue to exist ... the complacency of principal and supervising inspectors.

The approved training program appeared to be a document necessary to satisfy the legal requirements, but was of little practical value ... many negative comments left no doubt of substandard performance ... An air of unwillingness to “tangle” with the carrier was prevalent. Amendments to comply with the Administrator’s actions of March and April ... and ODCM 62-11 regarding emergency crew training were ignored.

The unwillingness to downgrade or override a company check pilot’s decision ... Principal Inspectors attempted to defend the company pilot, and refused to take actions while questioning the inspector’s reports ... actions taken by FAA management personnel appear to be in defense of the operator rather than being conducive to achieving a high level of safety ... known unsafe conditions have developed into highly critical situations ... An inspector recommended to the Principal Inspector that the designation of a company check pilot be rescinded had been made in numerous instances. The check pilot was found to be still in business ... The problem is serious with respect to follow-up action on discrepancies reported by inspectors. ... A need for reevaluation of the quality and effectiveness of the FAA approved training program was evident. ... Unqualified personnel conducting flight checks and large numbers of enroute inspections. Many remarks shown on reports indicated that the company proficiency program was a farce. Many of these remarks related to United Airlines and the FAA Denver office.

“I wouldn’t allow my family to go around the field
With one of them at the controls.”

The problem of obtaining satisfactory safety standards existed even at the FAA training center for inspectors at Oklahoma City. A friend of mine who is now deceased, Jack Druoin, instructed FAA inspectors in Boeing 720s at Oklahoma City. He complained to me that he and other instructors frequently protested that the inspectors were unsafe as pilots and couldn’t possibly pass a flight check. “I wouldn’t let my family go around the field with one of them at the controls,” Druoin grumbled.

Druoin complained that FAA management pressured the flight
Structors to pass unacceptable FAA inspectors on their flight checks, some of who were actually dangerous as pilots. When the FAA instructors refused to pass the pilots, FAA management then conducted the flight checks themselves. But this quickly stopped. Within a week after initiating this change, an uncontrolled hard landing and bounce resulted in major damage to a Boeing 720 jet.

“If this was United Airlines, you wouldn’t be doing this.”

Other airlines were aware of the peculiar control United Airlines had over the FAA. During a government hearing in Los Angeles to revoke the operating authority for a small air carrier, Stewart Air Service, the owner protested, “If this was United Airlines you wouldn’t be doing this.” He was right. I was one of the investigators who helped uncover irregularities at the small air carrier, and later found misconduct of far greater consequences at United Airlines.

**Deadly Consequences from the FAA Attitude**

Shortly after I joined the FAA in 1962 in Los Angeles, another inspector, Carl Whitman, found himself under attack. He had previously reported a dangerous piloting technique by an American Airlines captain during a flight check. The captain placed the 707 into a steep 45-degree bank shortly after takeoff during a low-airspeed noise-abatement climb. The captain repeated this dangerous bank during takeoff from New York City’s Idlewild Airport. The plane stalled, rolled upside down, and plunged into Jamaica Bay, with thousands of people watching. Everyone on the plane perished.

FAA management was upset following this crash. But not because the FAA inspector had not done more when the dangerous pilot technique showed up on the flight check. They were upset because the inspector reported the problem on the earlier inspection report.

**Flight Engineer Induced Emergency Descent**

A problem that gets no attention is the plunging level of flight engineer competency. The competency levels have declined for years, starting with the replacement of professional flight engineers with pilots who have little interest in learning the mechanics of the complex aircraft systems. In the 1950s the Air Line Pilot Association (ALPA) sought to increase their union membership by pushing for a third pilot, which would put four people in the cockpit. After considerable controversy over the matter, a presidential commission was appointed to study the matter. The Commission of aviation-ignorant members ruled in favor of the pilots’ union, and the decision was made that the engineer would be a pilot. The FAA failed to maintain the engineer competency standards, and proficiency rapidly deteriorated.

The increased reliability of the jets when they entered commercial service in 1958 prevented more crashes from occurring. No longer did the crew have the serious problems of frequent engine malfunctions and failures or runaway propellers that required immediate corrective actions. The decreased training and crew competency levels were offset by the
greatly increased reliability of the aircraft and engines, and greater assistance from air traffic controllers.

Escalating Confrontations

The FAA gave me a job to do, and that was to correct the mess responsible for the worst series of airline disasters in the nation’s history, and particularly at United Airlines. I tried to meet this responsibility despite the immense obstacles. My reports of the serious safety problems, the blatant violations of federal safety requirements, and the criminal falsification of records to cover up for the fraud, were threatening the scandals at United Airlines of which FAA management played a key role.

FAA officials applied pressure, threats, and intimidation to stop my reports, just as they did with other inspectors. Some inspectors transferred to other airline assignments. Some, like Frank Harrell, were forcibly transferred. The “smart” ones looked the other way. By not reporting the safety violations and problems, they joined the winning team.

I chose to fight the deep-seated culture, not knowing that this was the start of a David versus Goliath battle that affected me for the remainder of my life.

The greater the pressure, the harder I reported the problems, and there were many. Some of the most brutal air disasters occurred on United Airlines while I was fighting the corruption. My exposure actions threatened the status quo and threatened to expose long-standing corruption within the FAA that caused and made possible some of the nation’s most brutal air tragedies. I was obviously a threat to United Airlines and to FAA officials. Something had to give.

FAA Hatchet Man

Washington reacted to the developing crisis by sending a replacement supervising inspector to take charge of the Denver Air Carrier District office: Chuck Stacy. Initially, I thought the safety problems would improve, since Stacy knew the serious problems prior inspectors reported at United Airlines. Stacy knew the consequences in the New York City and Denver crashes.

Reporting Corruption Equals Unable to Get Along with Others

My first clue that Stacy was a “hatchet” man came within a few days. Before he hardly knew where his office was, let alone know of the complex problems, Stacy wrote a two-page memorandum accusing me of being unable to get along with others in a work situation. He supported this charge with my reports of United’s training program irregularities, reports similar to those reported by other inspectors for years, and which were our primary job functions. Stacy’s memorandum stated in part:

*I have reviewed considerable correspondence prepared by you relating to technical subjects and training requirements ... for United Airlines. Today, during our discussion concerning the adequacy of UAL's flight engineer training and checking, the subject was again recognizable.*

Stacy was referring to a morning staff meeting wherein one of the inspec-
tors stated: “If we push this,” referring to the correction of United’s training program deficiencies, “United will buck us, and not do anything.”

I replied, “The Agency has the authority and responsibility to take immediate corrective actions when safety irregularities are suspected. What United thinks doesn’t alter these responsibilities.” Stacy’s memorandum continued:

*With respect to our discussion of UAL flight engineer training ... the intent of the majority of your correspondence, although in numerous places it is inferred, or implied, is that UAL flight engineers are not meeting the CAR requirements. In view of the above, it is requested that you give careful consideration to the above subject."

The only consideration remaining, as implied by Stacy, was not make any more reports of the safety violations and safety problems. During several conversations, Stacy said to me,

*Your reports are a thorn in the side of the Agency. They’ll get the office in trouble if an accident investigation is made.*

It was clear that Stacy’s function was to halt my reporting of the serious safety problems and corruption at United Airlines.

As Stacy’s harassment continued and escalated on an almost daily basis, I called Al Butler, Chief of the Air Carrier Branch, in Los Angeles, to arrange for a meeting. During the meeting I described to Butler the multitude of safety irregularities and violations at United Airlines, the FAA blocking of corrective actions, and Stacy’s obsession with blocking my corrective actions.

*“I’ve had these problems myself.”*

Butler sympathized, “I know, Rod, I’ve had these problems myself when I was on the United assignment.” (Butler had held the primary DC-8 safety responsibilities at United during the New York City and Denver crashes, and knew the consequences of these same irregularities.) I later learned that he was present during the check at United Airlines San Francisco maintenance base where it was discovered that UAL’s flight managers were not providing the legally required training and check flights and covering up for these violations by falsifying their training records.

I complained about the high accident rate for Western Region air carriers, for which Butler held safety responsibilities. I described the incestuous relationship between FAA and United management. “I’m concerned about it also,” Butler replied. But his actions did not reflect concern. In Butler’s possession, though unknown to me at the time, was a recently received Washington evaluation report equating the high number of airline crashes with internal FAA problems in the Western Region. Butler knew the close relationship between these crashes and FAA Western Region misconduct, which included FAA refusal to act on known safety problems.

I told Butler that Stacy’s incessant attacks were forcing the continuation of the same problems that caused earlier crashes. Again, Butler sympathized. I felt higher FAA management was calling the shots: Lynn
Ashwell (Chief of the Western Region Air Carrier Branch); or William Krieger (Chief of Flight Standards in the Western Region). Butler knew he couldn’t fight the system.

Since the harassment blocking corrective actions occurred with Stacy’s arrival from Washington, the probability was that the pressures were directed from Washington. That meant that the protection of United Airlines was not confined to the Western Region, but came from offices in Washington.

Interference with the FAA’s safety functions worsened. Stacy was on a literal rampage, blocking me at every turn, and harassing me whenever he could. I requested another meeting in the Western Regional office to discuss the worsening problems, which was arranged for February 2 & 3, 1965. During this meeting I again described the serious safety problems and the FAA’s blockage of corrective actions.

**FAA Officials Violated Regulatory and Common-Sense Safeguards That Resulted in Tragedies**

Key FAA Western Region officials were present who made key decisions adversely affecting all aspects of operational safety of the airlines. Among those present were chief of the air carrier division, Al Butler; head of the Denver Air Carrier District Office, Chuck Stacy; chief of the Flight Standards Division, William Krieger.

During this hearing I described serious safety and criminal violations at United Airlines and the obstruction with the FAA’s air safety functions by the FAA itself. These were serious air safety and criminal violations. But they ignored what I had to say, and ignored my warnings of more crashes to come. Krieger told me to “get on the team or get out.”

“I won’t be a party to these activities!” I said. “If I have to request a congressional investigation, I’ll do it.” I also stated I would file an employee grievance protesting the safety irregularities and cover-up.

**An investigation of the entire FAA Flight Standards is necessary.**

The conference ended. Before leaving the building, one of the FAA officials (Chief, Air Carrier Division) guardedly wished me luck. He sympathized, knowing the gravity of what I was trying to expose, but smart enough to realize nothing would be done to correct the deeply ingrained corruption. Before leaving the FAA building on Manchester Avenue, I visited the legal counsel’s office to discuss the problems with an attorney friend, Rick Street. He knew the FAA problems, and the inability to get the FAA to investigate itself. He candidly stated:

*An investigation of the entire FAA Flight Standards is necessary.*

**Unprecedented Independent Prosecutor Role**

Something had to be done. I decided that filing an employee grievance protesting the cover-up and misconduct would require a hearing during which I could act similar to an independent prosecutor. This had never been done before, and probably would never be done again.
My position was similar to an FBI agent using the FBI employee grievance procedure to expose, for example, FBI ties to the Mafia. (What I would discover in subsequent years showed that this relationship did exist! I write about this relationship in some of my other books.)

**Full-Blown Smear Campaign Then Started**

The FAA management group then commenced actions to discredit me, to block my reporting of the air safety and criminal violations related to some of the past airline crashes. In that way FAA officials could respond to congressional or other inquiries by claiming the grievance hearing related to employee problems. These tactics constituted obstruction of justice.¹³

Before my assumption of the United assignment, and while working with American and Western Airlines in the Los Angeles area, the FAA had several times given me letters praising my technical ability and expressing appreciation for my attitude and hard work. This suddenly changed when I started reporting the ongoing corruption of key FAA management.

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¹³ Title 18 U.S.C. § 1505 (Obstruction of proceedings before government departments, agencies, ... Whoever, influences, obstructs, or impedes the due and proper administration of the law under which any pending proceeding is being had before any department or agency of the United States, or the due and proper exercise of the power of inquiry under which any inquiry or investigation is being had ... shall be fined ... or imprisoned ...”

Title 18 U.S.C. § 1512 (Tampering with a witness ... or informant.) Whoever knowingly uses intimidation ... or threatens another person ... or engages in misleading conduct toward another person, with intent to influence, delay or prevent the testimony of any person in any official proceeding; cause or induce any person to withhold testimony, or withhold a record ... from an official proceeding ... or conceal a record ... or hinder, delay, or preventing the communication to a law enforcement officer or judge of the United States of information relating to the commission or possible commission of a Federal offense ... shall be fined ... or imprisoned. Whoever intentionally harasses another person and thereby hinders, delays, prevents, or dissuades any person from attending or testifying in an official proceeding; reporting to a law enforcement officer or judge of the United States the commission or possible commission of a Federal offense.... shall be fined ... or imprisoned ...
United Airlines crash into the Brooklyn borough of New York City
Acting as Independent Prosecutor

In response to the serious problems within the FAA that allowed the massive safety problems and safety violations to continue at United Airlines, I filed papers under the Civil Service provisions that required the government to provide me the opportunity to conduct a hearing, subpoena government personnel for questioning under oath, and to enter written evidence. I was charging that people within the FAA were engaging in corrupt and criminal activities that played key roles in a series of specific prior airline crashes and that the same conditions existed. The hearing was conducted by a lawyer on the FAA administrator’s staff. The filing of this paper then started retaliation by FAA management—directly contrary to Civil Service provisions.

The Standard Government Psychiatric Tactic

Among the petty stunts these FAA officials pulled included charging me with psychiatric problems for reporting the safety irregularities. Stacy gave me a written memorandum and order:

*It is requested that a medical examination be made of Inspector Stich to determine his fitness for duty. It is believed the above request is warranted [because] I have found his performance to be marginal in the following areas: ... use of snap judgment ...*

*I have found in his conversation and correspondence, contradiction in some cases of facts; his method of communication [referring to the government reports required by my position] frequently involve distortion, insinuations and innuendos ... has frequently expressed quivering of lips, flushed face and inability to speak normally. This usually occurs during conversation wherein he has become argumentative, or is in the process of expressing his dislike of certain procedures, policy, et., pertaining to the Agency.*

Stacy would later testify at the hearing that my reports of violations and safety problems at United Airlines supported his allegations. Apparently any inspector reporting the tragedy-related safety violations was guilty of psychiatric problems, according to the mentality prevalent in the FAA Western Region. But my reports were similar to what other inspectors