

STATEMENT OF GUY S. GARDNER, ASSOCIATE ADMINISTRATOR FOR
REGULATION AND CERTIFICATION, FEDERAL AVIATION ADMINISTRATION,
BEFORE THE SENATE COMMITTEE ON COMMERCE, SCIENCE, AND
TRANSPORTATION, CONCERNING AVIATION ACCIDENT INVESTIGATIONS.
APRIL 9, 1997.

Mr. Chairman and Members of the Committee:

Mr. Chairman, I am Guy Gardner, and I am pleased to be serving as FAA's Associate Administrator for Regulation and Certification. I look forward to working with you and the other distinguished Members of this Committee on the many important and challenging aviation issues that face this Congress.

I welcome the opportunity to appear before you today. Accompanying me is Mr. Dave Thomas, Director of the FAA's Office of Accident Investigation. Before discussing the FAA's role in accident investigations, Mr. Chairman, let me take a moment to explain how our daily monitoring and surveillance activities ensure system safety. Using information obtained through our inspection program, pilot reports, service difficulty reports, hotline information, and daily contact with air carriers, manufacturers, and safety organizations--including the NTSB, the FAA and industry develop and implement a wide variety of safety initiatives.

Last year alone, for example, FAA issued 254 Airworthiness Directives, referred to as ADs. ADs are rulemakings that correct unsafe conditions, most of which are uncovered during routine system surveillance. ADs represent the accidents that did not happen

because of the FAA's and the industry's on-going monitoring of the system. They are a key element in accomplishing the FAA's mission of accident prevention. Other preventive actions occur throughout the system everyday when an FAA inspector works with an operator to correct a discrepancy before a flight takes off, or when a manufacturer's quality assurance program detects a manufacturing flaw and rejects a part. The safety record that we enjoy today results from our ability to uncover and solve potential problems before accidents happen.

Despite our best efforts, accidents do occur. When they do, the FAA and the NTSB work closely together during an accident investigation to identify where and how the system failed. Although both agencies share a common goal, our missions are somewhat different. The NTSB was established by Congress to investigate accidents, make determinations of probable cause, and to make safety recommendations to a regulating agency. The FAA is charged by the Congress with the job of advancing and maintaining the safety of our air transportation system through regulation, surveillance, and enforcement. Therefore, during an aviation accident investigation, the FAA's role is twofold; we must support the Board in conducting its investigation, and we must carry out our own review to ensure that safety is maintained.

The FAA's investigation of an accident may go beyond the specific circumstances of a particular accident and include, for example, a review of an air carrier's compliance with FAA regulations, maintenance and training manuals, and company procedure and

policies. The FAA may also check a pilot's training and medical history, flight time records, maintenance logbooks, airport and runway conditions if appropriate, and a host of other factors that may point to a breakdown in the system that either directly or indirectly relates to the accident. Anything relevant that the FAA uncovers during its own investigation is shared with the Board's investigation team.

If an unsafe condition is discovered, the FAA may issue emergency rulemaking requiring air carriers to correct or test an aircraft component, change a particular policy or procedure or, in rare cases, suspend certain types of operations. Emergency actions of this nature can occur while the Board is still conducting its investigation, even before it determines the probable cause of an accident and issues its recommendations. For example, on April 3, we issued an emergency AD requiring certain Boeing 767 operators to inspect wing flap system bolts within 15 days even though the NTSB investigation is still underway. The action was taken both as a preventive safety measure, and also as a means to obtain information to determine whether further corrective action is needed.

While fulfilling its own safety mandate, the FAA also provides all the support necessary for the NTSB's investigation. As soon as the FAA is notified of an accident the local Flight Standards District Office begins to gather facts and prepare data for the Board's investigation. In addition, our Operations Center notifies NTSB Headquarters and the appropriate NTSB field office responsible for the geographic area in which the accident has occurred. The first few hours following a major accident are hectic, and the

Operations Center will stay in contact with all necessary parties and provide teleconferencing, paging, and any other communication service necessary to help the NTSB team organize.

While information is gathered and the parties are being notified, the FAA begins to arrange transportation to the accident site for the NTSB team members and FAA staff. Last year we provided 37 flights for NTSB personnel. These services include the use of FAA aircraft, fuel, and pilot services. In rare cases, when the FAA aircraft and crew cannot serve the needs of the NTSB team, the Coast Guard provides the needed air transportation. These services are not limited to aviation accidents. Last year we transported the NTSB to 6 non-aviation accident sites.

Once the investigation is underway, FAA provides numerous other services to the NTSB. The FAA's Civil Aeromedical Institute in Oklahoma City, referred to as CAMI, stands ready to provide the NTSB with medical services such as pathological and toxicological testing, as well as the funding necessary for autopsies and other post-mortem examinations. In calendar years 1994 through 1996, CAMI paid for 845 autopsies at a cost of \$445,000. In 1995 and 1996, CAMI provided pathology services for approximately 900 accident victims at a cost of approximately \$700,000 dollars.

The FAA Technical Center in Atlantic City also provides investigation support in the form of component testing and research. In 1995, the FAA provided \$260,000 to

specially equip a leased airplane in order to conduct special testing during the USAir Boeing 737 investigation. Operating the FAA's Boeing 727 with the specially equipped aircraft flying behind, the Technical Center conducted tests to simulate wake vortex conditions that may have affected the USAir accident scenario. Another example of the Technical Center's accident support activities is the fire testing conducted during the ValuJet investigation.

The Board keeps the investigation team together and continues any necessary testing for as long as it takes to develop a full factual record of the accident. Every team member reviews and agrees to the factual record before the team disbands. The task of analyzing the facts and determining the probable cause of the accident, and issuing safety recommendations, lies solely within the province of the NTSB.

The FAA carefully weighs the Board's factual analysis and safety recommendations. In fact, the historical record of FAA's responses to NTSB recommendations shows the value we place on the Board's work. Of the 3,123 NTSB recommendations that have been closed, 84% have been close "acceptable" by the Board. The FAA's closed "acceptable" rate on the Board's Class I (urgent) recommendations is 90%.

To ensure timeliness in responding to NTSB recommendations, we have established a process for tracking each recommendation. We have consistently met the requirement to provide our initial response to an NTSB recommendation within 90 days. We also

continue to track and monitor the status of FAA review and action on each recommendation until final action is taken by the agency. Nevertheless, there are—as there should and will be—times when we differ on a particular course of action that should be taken.

It is important to understand that in most cases where the Board finds the agency's response to be "unacceptable," the agency has taken substantial action to address the Board's concern. For example, the FAA and the NTSB disagreed on the action taken by the FAA in response to a Board recommendation concerning certain General Electric engines. Following an uncontained failure of a high pressure compressor, the NTSB issued an urgent recommendation to require a new inspection interval which "... should be appropriately less than 4,000 cycles." The FAA agreed with the intent of the recommendation and conducted extensive research on the best way to resolve the issue which affected a large number of engines. Based on the research and engineering analysis performed by our technical experts in the FAA's Engine Directorate in Boston, we issued an AD that established a 3,500 cycle inspection interval. We met with Board staff to explain our analysis and solution and, although FAA is confident that the safety problem was fully addressed, the Board disagreed believing that the inspection interval should have been between 2,000 and 3,000 hours. Although extensive research was conducted and an AD was issued, the Board closed the recommendation as "unacceptable."

Although the two agencies do, on occasion, disagree on the best approach for carrying out a recommendation, it is important to note that there is a fundamental difference between recommending that a particular course of action be followed and bearing responsibility for developing the most effective approach to implementing that action. The NTSB is not responsible, nor in my view should it be, for considering the technical ramifications or the potential burdens and costs that may result from the industry-wide implementation of a recommendation. It provides FAA with its unvarnished safety recommendations. Concurrent with our technical safety evaluation of those recommendations, we must also consider the impact of applying a particular recommendation to the entire aviation community. For that reason, we typically examine whether there may exist non-regulatory or alternative regulatory means of achieving the safety objectives, which can optimize the safety benefits to air travelers. Although the FAA and the Board may differ on a particular course of action that should be taken, we are able to find common ground more often than not, and I believe that the safety dialogue between the two agencies does advance the safety interest of the traveling public.

In closing, Mr. Chairman, I want to assure you and that we will continue to work with and support the Board in its critical safety mission. I believe the two agencies have an effective and successful working relationship.

That concludes my prepared statement. I would be please to answer any questions that you or the members of the Committee have at this time.