Statement of Captain Scott Burke

Background:

Flight 292

Date: 09/21/05

Location: KBUR departure, KLAX arrival

Crewmembers: CA Burke, FO Razler, F1Meehan, F2 Arce, F3 Barreto, F4 Soderlund

Field Conditions: "I", 180/7, 10SM, CLR, 29/10, 29.92, 08/15 arrivals and departures

Narrative:

On September 21, 2005, I was assigned as Captain for Flight 292. Prior to push back, I performed the exterior preflight inspection of aircraft. I did not note any abnormalities. I confirmed the final load manifest numbers with station operations and requested adjustment of the departure fuel to 32,500 lbs fuel. Under my supervision, First Officer Razler built MCDU flight plan. We performed all checklists and briefings and performed a two-engine taxi due to the anticipated brief taxi time. We did not note any abnormalities during boarding, pushback, or taxi to runway 15. The block time was as follows: Out: 22:17Z Off: 22:31Z.

The clearance at BUR was as follows:

BUR..VNY7..DAG..J100..BCE..EKR..BFF..J94..PMM..J70..LVZ..LENDY 5..JFK, squawk 6727, alt 350, equip A-320 / Q, proposed 2220Z, remarks: maintain 4000 expect req. alt 10 minutes aft T/O, frequency 124.6

The takeoff configuration was as follows:

TOGA, Flaps 3, APU bleed on with packs, taxied into position and applied power prior to brake release. Captain = PM (pilot monitoring), First Officer = PF (pilot flying)

The takeoff and callouts were normal until I called "positive rate" and First Officer Razler called "gear up". I attempted to retract gear, but was unable to do so as gear handle was locked in position. I subsequently attempted to raise the landing gear handle, however, the following ECAM's displayed upon exit from TO inhibit:

L/G Shock Absorber Fault N/W Steer Fault

Upon check in with SOCAL departure, I reported that we could not retract the gear and I requested delaying vectors. We complied with the ECAM instructions and I referenced the FCOM for additional information/instructions. SOCAL departure provided numerous vectors and then handed us off to LA

center. Eventually we received a series of box-like vectors while orbiting over the Lancaster / Palmdale area ("PMD") at 14,000ft initially.

During this time, I made numerous attempts to engage both autopilot and autothrust without success. While orbiting, I notified JetBlue Inflight crewmembers and passengers that there was a landing gear abnormality. I advised that we were diagnosing the issue and devising a course of action. The Inflight crewmembers informed us that our flight was "on TV."

While orbiting the PMD area, I initiated ARINC communications with JetBlue (First Officer Razler remained the pilot flying and he assumed responsibility for ATC communications). I had extensive communications with both dispatch and maintenance control. Maintenance control performed a remote AIRMAN diagnostic and informed me that it was believed that the malfunction was an indication issue. Nevertheless, we mutually decided that the safest course of action would be to divert to LGB to ensure that the nose-wheel was not canted 90 degrees perpendicular to the aircraft center.

I advised the Inflight crew that we would be diverting to LGB so that we could perform a low altitude pass to verify the landing gear status. I also told the Inflight crew that if the gear status was favorable, a 'normal' landing without NW steering would be performed at LGB, which would necessitate a towin to the gate. I provided this same information to the passengers through the PA system. Following the announcement, I notified the Inflight crew to prepare for landing.

The conditions at LGB were as follows: "P", 300/8, 10, CLR, 27/13, 29.90, runway 30. Upon descent into the LGB area (still under SOCAL control at the time), I contacted the LGB tower on radio #2 to discuss situation and to request tower verification of nose wheel status. The tower recommended that we do a low altitude flyby at tower height.

SOCAL provided us with radar vectors for LGB ILS 30 approach. SOCAL handed our flight off to LGB tower and LGB granted us permission for a flyby. At LGB, the configuration was as follows: gear down, flaps 3, no autopilot, no autothrust, tower height. During low altitude flyby FO was Pilot Flying and Captain was Pilot Monitoring.

Traffic watch helicopters provided us with the initial confirmation that our nose gear was in the 90 degree position. LGB tower verified the position of our nose gear. We performed a climb out and reestablished communication with SOCAL, and I requested delaying vectors so that I could communicate with JetBlue. I received box-type radar vectors in the area between Santa Catalina Island and the LGB harbor area at 6,000 ft. Because the fuel status of the aircraft was approximately +20,000 lbs fuel, we had time to consider additional options. I declared an inflight emergency at this time.

First Officer remained the pilot flying and assumed responsibility for ATC communication and compliance while I recommenced ARINC communications with company. From this point forward, I was in continuous communication with company representatives, including dispatch, MX control, system chief pilot, A-320 standards captain, and others. The topics discussed included: (1) the possibility of regaining nose wheel alignment through system manipulation, (2) the most desired fuel state for optimum rearward CG, (3) the appropriate checklist to apply, (4) the most desirable aircraft configuration for landing, (5) the aircraft ground handling characteristics, (6) passenger management and availability of resources once on ground. During these conversations, we considered the following

alternate landing fields (Edwards Air Force base and Miramar Marine Corps Air Station). However, I determined that LAX was the best landing field because it had optimum field conditions, runway length, and a desired matrix of emergency / abnormal support services.

In consultation with the company, we decided to perform an emergency landing at LAX with flaps full, no ground spoiler, no autobrake, and no reverse thrust. We also decided to attempt to fly with nose gear onto runway with minimum vertical impact speed. Furthermore, once the aircraft was on the ground and directional control was established on landing rollout, we decided we should select the engine fire pushbuttons in order to minimize potential fire hazard resulting from possible FOD ingestion due to nose gear disintegration. There is no specific FCOM procedure or reference for landing the A-320 with the nose wheel canted 90 degrees. However, the "Landing With Abnormal L/G" FCOM reference 2.18 does stipulate to shut down the engines before touchdown.

The conditions at LAX were as follows: "F", 240/13, 10SM, Few 070, 21/14, 29.92, planned runway was 25L due to 200 ft. width.

I informed the Inflight crewmembers to prepare the cabin for an emergency landing at LAX and instructed the Inflight crew to move all passengers in the forward cabin to the aft (move CG aft). Additionally, I instructed the Inflight crew to move all bags in the overhead compartments, space permitting, aft. I also instructed the Inflight crew to reposition bags in the overhead compartments coincidental with emergency exit row seating.

I informed the Inflight crew that emergency evacuation of the aircraft on the runway would only be performed if absolutely necessary. I further instructed the Inflight crew that once the aircraft had stopped that they should expect to receive the "cabin crew at stations" command from me, and that they were to await further instructions from me regarding the requirement for emergency evacuation. I also informed the Inflight crewmembers that if the nose gear did collapse that emergency egress from the rear emergency exits might not be possible due to additional height above ground combined with emergency exit slide length limitations.

I discussed the emergency landing with First Officer Razler. We reviewed the checklists and discussed actionable items with an emphasis on who would perform them and when on the approach they would be accomplished. We mutually decided that the ram air valve would be opened at 1000 ft agl to assure cabin depressurization and emergency exit operation and to broadcast the "brace" command over the PA at 500 ft agl.

As previously discussed with the company, the decision fuel point was 10,000 lbs. remaining. We had been assured by the A-320 Fleet Standards Captain that fuel state would not adversely affect aircraft CG and handling once the center section fuel tank had been exhausted.

Once First Officer Razler established vectors for emergency landing at LAX, transition of control occurred so that I was the Pilot Flying and First Officer Razler was the Pilot Monitoring.

The descent was uneventful. We complied with the checklists and completed the action items. Once the nose gear made contact with the runway, I did not note any asymmetric forces. The aircraft continued to track runway centerline and little or no intervention was required. The nose gear touchdown occurred between 120 and 110 knots (estimated). First Officer Razler depressed engine fire pushbuttons approximately 5 seconds after affirmative ground control was established (speed unknown). I applied symmetrical braking at approximately 3000 ft.

Upon stopping, I set the parking brake and advised "cabin crew at stations". Independent confirmation of a no-fire status was provided both on VHF communication and CFR personnel who by this time had surrounded the aircraft. Because I did not know whether or not the nose landing gear would remain erect, the cabin crew remained at stations.

Once the air stairs had been brought to the aircraft I advised the #1 inflight crewmember to disarm then open the forward left entry door. All other emergency exits remained in the closed and armed position. Once aircraft stability had been assured and the nose gear examined, the passengers were allowed to exit the aircraft and board the waiting buses. While the First Officer stayed topside, I remained at the bottom of the airstair while the passengers exited the aircraft. Once all passengers disembarked, I returned to the aircraft at which point the FAA asked us to present our airman certificates and the aircraft MX logbook for their review.

A short time thereafter, I had a telephone conversation on my private cell phone with JetBlue executives who advised me that there was a bomb threat directed against the aircraft. We quickly exited the aircraft as we had been instructed to do. With the exception of the external lights being selected off, the aircraft cockpit configuration remained unaltered from the landing configuration. It was only upon reaching the terminal building that I remembered that the CVR circuit breakers had not been pulled. I relayed this information to the LGB Chief Pilot who in turned relayed this to company MX personnel.

Upon arrival to the terminal building, the entire crew was escorted to a secure conference room. Kristin Dunst, NTSB Investigator and Donald Griffin, FAA interviewed the crew.

Near the conclusion of the crew debrief, First Officer Razler and I voluntarily submitted to alcohol and controlled substance testing. A split sample for the controlled substance testing was provided.

Upon release by FAA / NTSB, JetBlue transported the crew and me to the LGB Hyatt.

Respectfully submitted,

----- Scott Burke
