

Statement of First Officer David Razler

Flight 292 Event Summary

Background:

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:

I was assigned as the flying pilot on the BUR/JFK flight on September 21, 2005. The Captain performed the exterior preflight inspection of aircraft and did not note any abnormalities. I built the MCDU flight plan, which was reviewed by the Captain. The Captain confirmed final load manifest numbers with station operations and requested departure fuel adjustment to 32,500 lbs fuel. All checklists and briefings were performed and there were no abnormalities noted during boarding, pushback, or taxi to runway 15. A two-engine taxi was performed due to anticipated brief taxi time.

The flight block times were as follows: Out: 22:17Z Off: 22:31Z. The clearance at Burbank 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.

The takeoff was normal and the callouts were normal until the Captain called "positive rate" and I called "gear up". The Captain attempted to retract the gear and was unable to do so as the gear handle was locked in position. The Captain subsequently attempted to raise the landing gear handle. 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, the Captain reported the inability to retract and requested delaying vectors. ECAM instructions were complied with and the Captain referenced the FCOM was referenced for additional information / instructions. SOCAL provided vectors and eventually a series of box-like vectors were provided while orbiting over the Lancaster / Palmdale area at 14,000ft initially. I made numerous attempts to engage both autopilot and autothrust without success. While orbiting, the Captain notified both inflight and passengers of the landing gear abnormality and told inflight and passengers that a diagnosis was being performed and a course of action was being devised. The inflight crewmembers informed us that our flight was "on TV". At this point we assumed that air-to-ground communications were being monitored.

While orbiting the PMD area, I remained FP and assumed responsibility for ATC communications while the Captain initiated ARINC communications with company. The Captain had extensive communications with both dispatch and maintenance control. MX control performed a remote AIRMAN diagnostic and concluded, from that diagnostic, that the malfunction was an indication issue only. We (Crew and Maintenance) mutually agreed to divert to LGB due to availability of company resources, spare aircraft, long runway, and CFR capability. The conditions at LGB were as follows: "P", 300/8, 10, CLR, 27/13, 29.90, runway 30

The Captain advised the inflight crew of the diversion to LGB and that a low altitude pass would be performed to verify landing gear status. Furthermore, the Captain told the inflight crew that if gear status was favorable, a 'normal' landing without NW steering would be performed at LGB that would necessitate a tow-in to the gate. The Captain provided this information by PA to the passengers and notified the inflight crew to prepare for landing.

Upon descent into the LGB area (still under SOCAL control at the time), the Captain contacted LGB tower on radio #2 to discuss situation and to request tower verification of nose wheel status. Tower recommended a low altitude flyby at tower height. SOCAL provided radar vectors for LGB ILS 30 approach and handoff to LGB tower was initiated, followed by permission to flyby. The configuration at LGB was: gear down, flaps 3, no autopilot, no autothrust, tower height.

Traffic helicopters initially confirmed the nose gear was in a 90 degree position. This was verified by LGB tower. I performed a climb out and the Captain reestablished communication with SOCAL. The Captain requested delaying vectors so that additional communication with company could be performed. The Captain was provided with box-type radar vectors in the area between Santa Catalina Island and the LGB harbor area at 6,000 ft. The fuel status of aircraft was approximately +20,000 lbs fuel, which allowed us to consider additional options. An inflight emergency was declared at this time.

I was the flying pilot and assumed responsibility for ATC communication and compliance while the Captain initiated ARINC communications with company. From this point forward, the Captain maintained continuous communication with company representatives, including Dispatch, MX control, system chief pilot, A-320 standards captain, and others. We considered alternate landing fields (Edwards Air Force base and Miramar Marine Corps Air Station), but the Captain and the company representatives determined that LAX had optimum field conditions, runway length, and a appropriate emergency /abnormal support services.

We and the Company decided that we would perform an emergency landing at LAX with flaps full, no ground spoiler, no autobrake, no reverse thrust. We, along with QRH also decided that we would attempt to fly nose gear onto runway with minimum vertical impact speed. Once the aircraft was on the ground and directional control was established on landing rollout, we, based on the circumstances present, decided that the engine fire pushbuttons would be selected in order to minimize potential fire hazard resulting from FOD ingestion due to nose gear disintegration.

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.

The Captain informed inflight crewmembers to prepare the cabin for an emergency landing at LAX. The Captain directed that all customers be moved as far aft as possible (move CG aft) and directed that all bags be moved aft as well, space permitting. The Captain also directed the Inflight crewmembers to reposition the bags out of the overhead compartments over the emergency exit rows.

The Captain informed the inflight crew that emergency evacuation of the aircraft on the runway would only be performed if absolutely necessary; that once the aircraft had stopped they should expect the "cabin crew at stations" command from the Captain. He also directed that they were to await further instructions from the cockpit regarding the requirement for emergency evacuation.

I discussed the impending emergency landing with the Captain. 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. It was mutually decided that the ram air valve would be opened at 1000 ft agl to assure cabin depressurization and emergency exit operation. Furthermore, the "brace" command would be broadcast over the PA at 500 ft agl.

As had been previously disclosed to company, the decision fuel point was 10,000 lbs. remaining. Once established on vectors for emergency landing at LAX, the transition of control occurred so that the Captain was the pilot flying and I was the pilot monitoring.

The descent was uneventful; we complied with the checklists and completed actionable items that we had discussed. During the landing flare I called out the radio altimeter to the Captain, from 5 to 0 until touchdown. After touchdown I called out airspeeds to the Captain. Nose gear touchdown occurred between 120 and 110 knots (estimated). I depressed engine fire pushbuttons approximately 5 seconds after affirmative ground control was established (speed unknown).

The Captain applied symmetrical braking at approximately 3000 ft. Upon stopping, the Captain set the parking brake and advised "cabin crew at stations".

Independent confirmation of a no-fire status was provided on VHF by CFR commander who by this time was directly in front of the aircraft. 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 I stayed topside, the Captain remained at the bottom of the airstair while the passengers exited the aircraft. Once all customers were off the aircraft we were asked to present our airman certificates and the aircraft MX logbook to FAA for review.

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 the Captain remembered that the CVR circuit breakers had not been pulled. This information was relayed to Charlie Andrews, the LGB Chief Pilot, who relayed this to company MX personnel.

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

Near the conclusion of the crew debrief, the Captain and I voluntarily submitted to both alcohol and drug testing by company personnel.

Upon release by FAA / NTSB, the crew was transported to the LGB Hyatt.

Respectfully submitted,

First Officer David Razler
