



Aviation Investigation Final Report

Location:	MIAMI, Florida	Accident Number:	MIA01FA029
Date & Time:	November 20, 2000, 12:22 Local	Registration:	N14056
Aircraft:	Airbus Industrie A300B4-605R	Aircraft Damage:	Minor
Defining Event:		Injuries:	1 Fatal, 3 Serious, 19 Minor, 110 None
Flight Conducted Under:	Part 121: Air carrier - Scheduled		

Analysis

After takeoff from Miami, the flight experienced a pressurization system malfunction, which the captain identified as the airplane depressurizing. The flight attendants and passengers complained of pain in their ears at that time. The flight crew placed the pressurization system into manual control, turned off the autopilot and autothrottle systems, and began a descent to return to Miami. During the return to Miami, several lavatory smoke alarms activated and the captain call light illuminated in the cabin; however, no evidence of fire or smoke was found. The flight crew did not complete the checklists for manual pressurization control and emergency landing during the return to Miami, both of which called for the airplane to be depressurized prior to landing. After landing and stopping on a taxiway, the captain also noticed an aft baggage compartment fire loop light illuminated, prompting him to evacuate the airplane. After the captain ordered the evacuation, the flight attendants attempted to open the doors. The doors would not open. The flight attendant/purser at the L1 (front left passenger) door continued to attempt to open the door, and the door explosively opened, ejecting the flight attendant/purser from the airplane to the ground, causing fatal injuries. The remainder of the doors opened and the airplane was evacuated. The emergency evacuation checklist did not call for the flight crew to check for depressurization of the airplane prior to commanding an evacuation. Post-accident examination of the airplane revealed that insulation blankets, which had been manufactured and replaced by the airplane operator's maintenance personnel, had not been properly secured per the airplane manufacturer's data. The blanket had migrated over to, and partially blocked, the forward and aft pressurization outflow valves, leading to the pressurization system malfunction. The forward outflow valve was found 3/8-open and the aft outflow valve was found fully closed. The lavatory smoke alarms were found to activate when subjected to abnormal pressure. There were no FAA technical standards for the lavatory smoke detectors. A sensor in the aft cargo compartment was found out of tolerance and also activated when subjected to abnormal pressure. The cabin doors were found to have no means for relieving pressure prior to opening the doors. The cabin altimeter in the cockpit did

not have a mechanical stop in the negative direction, and under excessive pressure conditions, allowed the needle to move past the negative range into the high positive range. The aircraft manufacturer stated that when the pressurization system is in the manual mode, the outflow valves do not automatically open during landing and that a person cannot open a door if the airplane is pressurized above approximately 1.5 psi differential. As result of this investigation, the Safety Board previously issued 18 safety recommendations to the FAA.

Probable Cause and Findings

The National Transportation Safety Board determines the probable cause(s) of this accident to be: The failure of the flight crew to perform the cabin pressurization manual control abnormal checklist after experiencing a pressurization system malfunction and switching to manual pressurization control, and the failure of the flight crew to perform the emergency landing checklist prior to landing, resulting in the airplane having an excessive cabin pressure level after landing which led to a rapid decompression of the airplane when a flight attendant opened door and was ejected out of the airplane during emergency evacuation that was initiated by the captain. Contributing to the accident was the failure of operator maintenance personnel to ensure that insulation blankets around the forward and aft outflow valves were properly secured in accordance with airplane manufacturer's data, resulting in a malfunction of the pressurization system. Other contributing factors include the absence of FAA requirements that each emergency exit door has a system to relieve pressure or contain specific warnings (such as lights, placards, or other indications that clearly identify the danger of opening the emergency exit doors when the airplane is over pressurized); the absence of FAA technical specifications for lavatory ionization smoke detectors; the absence of a requirement in the airplane's ground/emergency evacuation checklist for the flight crew to ensure that the cabin differential pressure is zero pounds per square inch before signaling flight attendants to begin an emergency evacuation; and the absence of a mechanical stop in the negative direction on the cabin altimeter gauge.

Findings

Occurrence #1: AIRFRAME/COMPONENT/SYSTEM FAILURE/MALFUNCTION
Phase of Operation: CLIMB - TO CRUISE

Findings

1. AIR COND/HEATING/PRESSURIZATION,OUTFLOW VALVE - BLOCKED(PARTIAL)

2. (C) MAINTENANCE, INSTALLATION - IMPROPER - COMPANY MAINTENANCE PERSONNEL
3. AIR COND/HEATING/PRESSURIZATION - FAILURE, PARTIAL

Occurrence #2: DECOMPRESSION

Phase of Operation: STANDING - ENGINE(S) NOT OPERATING

Findings

4. (C) CHECKLIST - NOT FOLLOWED - FLIGHTCREW
5. FUSELAGE, CABIN - PRESSURE EXCESSIVE
6. EVACUATION - INITIATED - PILOT IN COMMAND
7. DOOR, PASSENGER - EXPLODED
8. FUSELAGE, CABIN - DECOMPRESSION
9. MISCELLANEOUS - FLIGHT ATTENDANT

Factual Information

HISTORY OF FLIGHT

On November 20, 2000, about 1222 eastern standard time, an Airbus Industrie A300B4-605R, N14056, registered to Wilmington Trust Company, and operated by American Airlines, Inc., as flight 1291, a Title 14 CFR Part 121 scheduled international passenger flight, from Miami, Florida, to Port Au Prince, Haiti, had a flight attendant receive fatal injuries during an emergency evacuation after the flight returned to Miami. Visual meteorological conditions prevailed at the time and an instrument flight rules flight plan was filed. The aircraft received minor damage and the airline transport-rated pilot, first officer, 5 flight attendants, 3 other crewmembers, and 100 passengers were not injured. One flight attendant received fatal injuries, 3 passengers received serious injuries, and 1 flight attendant and 18 passengers received minor injuries. The flight originated from Miami, Florida, the same day, about 1149.

According to American Airlines, Inc. records, the captain reported for the accident flight at 1010 and the first officer reported at 1020. The flight crew received departure paperwork for the flight that included airplane information, weight and balance information, NOTAMS and weather information. Flight 1291 departed the gate at 1120 and was airborne at 1149. The first officer was the pilot flying.

At 1156, during the climb to flight level 230, at about 16,000 feet above mean sea level (msl), the captain stated to the copilot that the airplane was depressurizing and for him to get the airplane down. The first officer disconnected the autopilot and began a descent. The flight crew notified Miami Air Route Traffic Control Center of a pressurization problem and requested a descent to 10,000 feet. Miami Center cleared flight 1291 to descend to 10,000 feet. The captain switched to manual pressurization control. At about 1159, after leveling at 10,000 feet, the flight crew advised the controller that they were unable to control pressurization and requested a clearance to return to Miami. The controller assigned a heading of 115 degrees and instructed the flight crew to contact Miami Approach Control.

At about 1214, after being cleared to land by the Miami Air Traffic Control Tower, the captain declared an emergency, requested fire equipment to stand-by and stated to the tower controller: "we are getting some warnings of a fire, although there is no evidence of a fire at this time." Flight 1291 landed in Miami at about 1218. Total flight time for this abbreviated flight segment was 29 minutes.

Shortly after landing, the airplane stopped on the taxiway and the flight crew requested fire personnel to inspect the exterior of the airplane for any visible evidence of fire. At about 1220, after being cleared to taxi to the ramp, a flight attendant called the captain on the intercom and reported a smell of smoke in the middle lavatory. She said it smelled like rubber burning.

Immediately following this communication, the captain stated that he noticed that one of the cargo compartment fire detection loop lights was illuminated. He informed the ground controller, "we have a fire and we are going to evacuate right here."

The flight attendants experienced difficulty opening the cabin doors when the emergency evacuation was initiated. The captain was notified of this difficulty. While the captain was evaluating the problem, he said he heard a "whoosh" sound and then the cabin doors opened, emergency slides deployed and passengers evacuated the airplane.

At the captain's command to evacuate, the purser went to the L1 door and tried to open it, using one hand. The door would not open. The purser went back to the cockpit to tell the flight crew. The purser then came out of the cockpit and tried to open the door using both hands. He also heard someone from the back of the airplane state that the doors were not opening. Also, the number three and number four flight attendants stated their doors would not open. He was watching the purser out of the corner of his eye when all of a sudden there was an explosion. He was being pulled toward the L1 door and hit the corner of the lavatory and the L1 jump seat. He fell to the floor and blacked out momentarily. When he awoke the L1 door was open and the purser was on the ground about 60 feet from the airplane.

PERSONNEL INFORMATION

The captain held an Airline Transport Pilot certificate last issued on May 2, 1996, with airplane multiengine land, and instrument airplane ratings. He also held type ratings in the Airbus A-300B4-605R/A-310, Boeing 757 and 767, and Lockheed 300. At the time of the accident, the captain held an Federal Aviation Administration (FAA) first class medical certificate dated June 15, 2000. American Airlines hired the captain on February 8, 1985. A review of FAA records found no accident, incident or enforcement action. The captain last received a proficiency check in the Airbus A-300B4-605R on October 24, 2000.

The first officer held an FAA Airline Transport Pilot certificate last issued on June 22, 1999, with airplane single engine land, airplane multiengine land, rotorcraft helicopter, and instrument airplane and helicopter ratings. He also held type ratings in the A-300B4-605R/A-310 and the Lockheed L-382. At the time of the accident, the first officer held an FAA first class medical certificate dated, May 31, 2000, with no restrictions. American Airlines hired the first officer on June 29, 1998. A review of FAA records found no accident, incident or enforcement action. The first officer last received a proficiency check in the Airbus A-300B4-605R on June 13, 2000.

AIRCRAFT INFORMATION

The airplane was an Airbus Industrie A-300B4-605R, serial number 463, U.S. registration N14056, manufactured in 1988. The airplane was equipped with two General Electric CF6-80C2A5 engines, which are rated at 61,500 pounds of takeoff thrust each. At the time of the accident, the airplane had accumulated 34,346 total flight hours.

Logbook records show the airplane was last inspected on September 28, 2000, 345 flight hours before the accident, when the airplane received a "B" check in accordance with the American Airlines continuous airworthiness program. On November 9, 2000, the aft pressurization outflow valve was changed.

WEIGHT AND BALANCE

The following information was obtained from the flight departure paperwork:

Basic Operating Weight	206669 lbs.
Passenger Weight	21780 lbs.
Baggage Weight	11177 lbs.
Zero Fuel Weight	239626 lbs.
Maximum Zero Fuel Weight Allowed	288800 lbs.
Fuel	55600 lbs.
Ramp Weight	296626 lbs.
Maximum Ramp Weight Allowed	380500 lbs.
Taxi Fuel Burn	1400 lbs.
Actual Takeoff Weight	295226 lbs.
Maximum Takeoff Weight Allowed	323800 lbs.
Estimated Fuel Burn to PAP	18965 lbs.
Estimated Landing Weight	267000 lbs.
Maximum Landing Weight Allowed	308600 lbs.

Takeoff center of gravity (CG) was 26.1 percent of the mean aerodynamic chord (MAC) and was within the approved limits of the airplane.

METEOROLOGICAL INFORMATION

The Miami International Airport 1238 surface weather observation was winds from 330 degrees at 8 knots, visibility 10 statute miles, clouds scattered at 2,500 feet above ground level, temperature 83 degrees F, dew point temperature 70 degrees F, altimeter setting 30.09 inches Hg. Visual meteorological conditions prevailed at the time.

FLIGHT RECORDERS

The cockpit voice recorder (CVR) was a Fairchild model A-100A s/n 50909. The CVR was brought to the audio laboratory of the National Transportation Safety Board (NTSB) on November 21, 2000. The CVR Group convened on November 29, 2000. A transcript was prepared of the entire 30:59-minute recording.

The solid state flight data recorder (FDR), Fairchild model FA2100 (serial number 00857), was

removed from the aircraft and sent to the National Transportation Safety Board's laboratory in Washington, D.C. for readout and evaluation. A successful FDR readout was performed.

WRECKAGE AND IMPACT INFORMATION

The outflow valves and the compartments in which the outflow valves are located were inspected shortly after the accident for any signs of discrepancies which might have caused the pressurization problems reported by the flight crew. The aft outflow valve was noted to be in the fully closed position, and the forward outflow valve was in the 1/4 to 3/8 open position. Closer inspection of the aft outflow valve found that an insulation blanket was obstructing the intake side of the valve, and the blanket was drawn through the intake screen in some areas. Marks indicated the insulation blanket at sometime had blocked the butterfly of the outflow valve. In addition, many of the insulation blankets in the compartment containing the aft outflow valve were displaced from their proper positions and were not secured in place. Closer inspection of the forward outflow valve found that an insulation blanket was partially obstructing the intake side of that valve. This insulation blanket had impressions on it that were of the same size and shape as the complete intake grill. Inspection of the compartment containing the forward outflow valve and the forward cargo compartment found that many of the insulation blankets in these compartments were displaced from their proper positions and were not secured in place.

All seven of the aircraft's lavatories were inspected to look for any signs of smoke or fire. The lavatories' waste bins, water heaters, and overhead spaces were all checked and no signs of soot or fire were found. A cigarette was found at the bottom of the waste bin for lavatory Y. All of the galleys on the aircraft were inspected to look for any signs of smoke or fire. All of the ovens, waste containers, and food storage areas were inspected, and no signs of soot or fire were found. All of the cargo compartments on the aircraft were inspected for any signs of smoke or fire. All of the areas around the smoke detectors as well as other areas inside the cargo compartments and behind the cargo compartment walls were inspected, and no signs of soot or fire were found.

MEDICAL AND PATHOLOGICAL INFORMATION

Postmortem examination of the flight attendant who received fatal injuries during the emergency evacuation of the aircraft was performed by the Miami-Dade County Medical Examiner's Office. The cause of death was attributed to multiple blunt force injuries. Postmortem toxicology studies on specimens obtained from the fatally injured flight attendant was performed by the Miami-Dade County Medical Examiner's Office. The tests were negative for volatiles in chest blood and drugs in urine.

Post-accident toxicology testing on specimens obtained from the captain, first officer, six surviving flight attendants, and two flight service directors were negative for alcohol and drugs.

FIRE

There was no fire onboard the airplane in flight or after landing.

TESTS AND RESEARCH

The flight crew switched control of the pressurization system to the manual mode when they noticed a malfunction of the system during climb. The American Airlines, Inc., A-300 Operating Manual contains a procedure on page Air 5 of the Emergency/Abnormal Section, which the flight crew should follow after switching to manual control of the pressurization system. The procedure calls for the vertical speed control to be moved to the up or outflow valve full open position before landing. Also, the procedure calls for air conditioning packs 1 and 2 to be turned off on the ground and for the flight crew to check that the pressure differential of the airplane is zero before the doors are opened. A warning note on the page states: "On the ground both packs are selected off to ensure depressurization." The captain's A-300 Operating Manual was found open to this page after the accident. The flight crew stated that they did not complete the procedure for switching to manual pressurization. The forward outflow valve was found in the 3/8-open position and the aft outflow valve was found in the fully closed position after the accident.

The American Airlines A-300 Operating Manual contains a procedure on pages 4 and 5 of the Emergency/Abnormal Section, for Emergency Landing. The procedure lists "recommended actions before landing." Item 8 states, "Depressurize airplane and press Pack Switches Off. Ascertain that the differential pressure gauge reads zero." The flight crew stated they did not have time to complete this procedure because they were on final approach when the captain declared an emergency.

The American Airlines A-300 Operating Manual also contains the A-300 Emergency Procedures Checklist on pages 11 and 12. The Emergency Procedures Checklist contains a "Ground Evacuation" procedure. The "Ground Evacuation" procedure is also displayed on each pilot control wheel. The "Ground Evacuation" procedure does not call for the flight crew to check the differential pressure prior to commanding an emergency evacuation. The flight crew stated they did perform this checklist.

The flight crew's performance of the "Ground Evacuation" procedure required the crew to press in the RAM AIR switch. The American Airlines Computer-Based Training syllabus advises that "when the ram air switch is pressed in, the green "open" light illuminates, indicating that the ram air inlet is fully open to permit unrestricted ventilation, and also that both outflow valves are open." American Airlines' manuals replicate Airbus Industrie's operation and system description manuals concerning outflow valve operation. However, Airbus Industrie's manuals did not advise that the outflow valves will not move to a full open position when the RAM AIR switch is pressed in while in manual pressurization mode. The flight crew stated that upon selection of the RAM AIR switch during performance of the Emergency Evacuation Checklist, the illumination light indicated "OPEN." The flight crew was not aware that the RAM AIR switch

would not open the outflow valves if the pressurization system was being operated in manual mode.

During the accident flight, the flight crew reported that the lavatory smoke alarms sounded and an aft cargo compartment loop fault light came on. The lavatory smoke alarms all operate independently of each other, while the cargo compartment smoke detectors work in pairs. A cargo compartment loop light indicates that one of the two cargo compartment smoke detectors in that loop has detected smoke but the other detector has not. This indication can be due to a malfunctioning detector or an actual fire. All of the smoke detectors that sounded their alarms during the accident flight were of the ionization type. During post-accident testing, all of the detectors could be made to sound their alarms, without smoke present, when subjected to abnormal pressure levels.

The pressurization control system is a fully automatic, electrically operated system. It consists of two identical independent automatic systems operating two outflow valves, one situated forward of the air conditioning bay and the other aft of the bulk cargo compartment. Each valve is operated by one of three electric motors; two of these motors are controlled independently by the two automatic systems, and the third motor (for the manual system) is controlled by a toggle switch located on the overhead panel in the flight compartment. In each valve, the drive mechanism and butterfly valve are common to either system, and the two automatic systems will alternately operate both valves. Each system is used alternately for each flight, the changeover being affected automatically between flights. In the event of a system failure, control is automatically transferred to the other system. The system function is dependent on pre-programmed cabin pressure altitude, aircraft altitude, and pre-selected landing altitude information. This information is relayed to the pressurization controller of either of the two systems selected. These units also automatically control pre-pressurization and depressurization procedures.

The cabin pressure controllers, mounted in the avionics compartment, are electronic devices intended to optimize the pressure build-up in the cabin while minimizing pressure fluctuations. In automatic mode, the controllers monitor and control cabin pressure automatically during all phases of flight. After landing (main landing gear compressed), the automatic mode commands the outflow valves to a fully open position 45 seconds after touchdown. When the cabin pressure is being controlled in manual mode, the outflow valves do not open automatically after touchdown.

The cabin altimeter was exposed to increased pressure to determine at what value of increased pressure the indicator would read 20,000 ft. This value was found to be 1351.9 mb (40.03 in. Hg or 19.61 psia). Disassembly of the unit showed unit design did not include any mechanical pointer stops.

Examination of the insulation blankets that were loose and had moved over the intakes of the forward and aft outflow valves showed that they were not the original blankets supplied with the airplane. According to American Airlines, the blankets were manufactured by American

Airlines under the authority provided by CFR 14, 121.363 and 21.303b. Blankets nearest the forward outflow valve, which incorporated additional security incorporated by the airline, remained in place. Both compartments contained a mix of Airbus-and American Airlines-manufactured insulation. The American Airlines-manufactured insulation blankets did not have fasteners for securing the insulation blankets as recommended in Airbus data.

According to an e-mail from the FAA Seattle Aircraft Evaluation Group Program Manager for the A300 aircraft (Airworthiness), the A-300 and A-310 principal maintenance inspectors were informed of this accident and reported that of all U.S. operators, only American Airlines reported finding loose insulation blankets in their aircraft. American Airlines reported that four of their 33 aircraft inspected had loose blankets.

A review of records by U.S. Customs and American Airlines show no record that U.S. Customs Inspectors performed an inspection of the accident airplane between November 9, 2000, when the aft outflow valve was changed, and the time of the accident.

ADDITIONAL INFORMATION

The accident airplane was released by the NTSB to John Darbo, American Airlines Flight Safety Department, on December 6, 2000. Components retained by the NTSB for further investigation were later released to American Airlines.

Pilot Information

Certificate:	Airline transport; Flight engineer	Age:	44, Male
Airplane Rating(s):	Multi-engine land	Seat Occupied:	Left
Other Aircraft Rating(s):	None	Restraint Used:	
Instrument Rating(s):	Airplane	Second Pilot Present:	Yes
Instructor Rating(s):	None	Toxicology Performed:	Yes
Medical Certification:	Class 1 Valid Medical--no waivers/lim.	Last FAA Medical Exam:	June 15, 2000
Occupational Pilot:	Yes	Last Flight Review or Equivalent:	October 24, 2000
Flight Time:	13043 hours (Total, all aircraft), 4650 hours (Total, this make and model), 8612 hours (Pilot In Command, all aircraft), 135 hours (Last 90 days, all aircraft), 48 hours (Last 30 days, all aircraft), 7 hours (Last 24 hours, all aircraft)		

Co-pilot Information

Certificate:	Airline transport; Commercial; Flight engineer	Age:	36, Male
Airplane Rating(s):	Single-engine land; Multi-engine land	Seat Occupied:	Right
Other Aircraft Rating(s):	Helicopter	Restraint Used:	
Instrument Rating(s):	Airplane	Second Pilot Present:	Yes
Instructor Rating(s):	None	Toxicology Performed:	Yes
Medical Certification:	Class 1 Valid Medical--no waivers/lim.	Last FAA Medical Exam:	May 31, 2000
Occupational Pilot:	Yes	Last Flight Review or Equivalent:	June 13, 2000
Flight Time:	3598 hours (Total, all aircraft), 634 hours (Total, this make and model), 1670 hours (Pilot In Command, all aircraft), 111 hours (Last 90 days, all aircraft), 31 hours (Last 30 days, all aircraft), 7 hours (Last 24 hours, all aircraft)		

Aircraft and Owner/Operator Information

Aircraft Make:	Airbus Industrie	Registration:	N14056
Model/Series:	A300B4-605R A300B4-605	Aircraft Category:	Airplane
Year of Manufacture:		Amateur Built:	
Airworthiness Certificate:	Transport	Serial Number:	463
Landing Gear Type:	Retractable - Tricycle	Seats:	281
Date/Type of Last Inspection:	September 28, 2001 Continuous airworthiness	Certified Max Gross Wt.:	323800 lbs
Time Since Last Inspection:	345 Hrs	Engines:	2 Turbo fan
Airframe Total Time:	34346 Hrs at time of accident	Engine Manufacturer:	General Electric
ELT:	Installed, not activated	Engine Model/Series:	CF6-80C2A5
Registered Owner:	Wilmington Trust Company	Rated Power:	61500 Lbs thrust
Operator:	AMERICAN AIRLINES	Operating Certificate(s) Held:	Flag carrier (121)
Operator Does Business As:		Operator Designator Code:	AALA

Meteorological Information and Flight Plan

Conditions at Accident Site:	Visual (VMC)	Condition of Light:	Day
Observation Facility, Elevation:	MIA, 8 ft msl	Distance from Accident Site:	1 Nautical Miles
Observation Time:	12:38 Local	Direction from Accident Site:	90°
Lowest Cloud Condition:	Scattered / 2500 ft AGL	Visibility	10 miles
Lowest Ceiling:	None	Visibility (RVR):	
Wind Speed/Gusts:	8 knots / None	Turbulence Type Forecast/Actual:	/
Wind Direction:	330°	Turbulence Severity Forecast/Actual:	/
Altimeter Setting:	30.09 inches Hg	Temperature/Dew Point:	28°C / 21°C
Precipitation and Obscuration:	No Obscuration; No Precipitation		
Departure Point:	MIAMI, FL (MIA)	Type of Flight Plan Filed:	IFR
Destination:	PORT AU PRINCE, Haiti (MTPP)	Type of Clearance:	IFR
Departure Time:	11:49 Local	Type of Airspace:	Class D

Airport Information

Airport:	Miami International KMIA	Runway Surface Type:	Asphalt
Airport Elevation:	8 ft msl	Runway Surface Condition:	Dry
Runway Used:	30	IFR Approach:	Localizer only
Runway Length/Width:	9354 ft / 150 ft	VFR Approach/Landing:	None

Wreckage and Impact Information

Crew Injuries:	1 Fatal, 1 Minor, 10 None	Aircraft Damage:	Minor
Passenger Injuries:	3 Serious, 18 Minor, 100 None	Aircraft Fire:	None
Ground Injuries:	N/A	Aircraft Explosion:	None
Total Injuries:	1 Fatal, 3 Serious, 19 Minor, 110 None	Latitude, Longitude:	25.815,-80.296669

Administrative Information

Investigator In Charge (IIC):	Kennedy, Jeffrey
Additional Participating Persons:	TR PROVEN; Federal Aviation Administration; Washington, DC Michael Ginn; U.S. Customs; Miami, FL John Darbo; American Airlines; Fort Worth, TX John VanDeventer; Allied Pilot's Association; Forth Worth, TX Kathy Lord-Jones; Association of Professional Flight Attendants; Forth Worth, TX Ursuss Alvarez; Transport Workers Union; Miami, FL Geoff Corlett; Airbus Industrie; Toulouse
Original Publish Date:	February 28, 2006
Last Revision Date:	
Investigation Class:	Class
Note:	
Investigation Docket:	https://data.nts.gov/Docket?ProjectID=50666

The National Transportation Safety Board (NTSB) is an independent federal agency charged by Congress with investigating every civil aviation accident in the United States and significant events in other modes of transportation—railroad, transit, highway, marine, pipeline, and commercial space. We determine the probable causes of the accidents and events we investigate, and issue safety recommendations aimed at preventing future occurrences. In addition, we conduct transportation safety research studies and offer information and other assistance to family members and survivors for each accident or event we investigate. We also serve as the appellate authority for enforcement actions involving aviation and mariner certificates issued by the Federal Aviation Administration (FAA) and US Coast Guard, and we adjudicate appeals of civil penalty actions taken by the FAA.

The NTSB does not assign fault or blame for an accident or incident; rather, as specified by NTSB regulation, “accident/incident investigations are fact-finding proceedings with no formal issues and no adverse parties ... and are not conducted for the purpose of determining the rights or liabilities of any person” (Title 49 *Code of Federal Regulations* section 831.4). Assignment of fault or legal liability is not relevant to the NTSB’s statutory mission to improve transportation safety by investigating accidents and incidents and issuing safety recommendations. In addition, statutory language prohibits the admission into evidence or use of any part of an NTSB report related to an accident in a civil action for damages resulting from a matter mentioned in the report (Title 49 *United States Code* section 1154(b)). A factual report that may be admissible under 49 *United States Code* section 1154(b) is available [here](#).