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Did the "Butterfly Effect" Play a Key Role in the Conditions that Enabled the 9/11 Airline Hijackings to Occur?

This presentation seeks to raise long-overdue interest in the ripple effects, sometimes far removed, from the consequences of safety problems that are covered up because of their highly sensitive or political nature. And particularly their role in the conditions that enabled four groups of terrorists to hijack four airliners within a relatively short period of time. This presentation focuses primarily on the culture in the government's aviation safety offices and its relationship to a series of airline tragedies, with some reference to individuals in industry that, thank goodness, is not representative of most people in the aviation industry.

The facts that I state here are based upon my 60 years of hands-on aviation experience as a Navy Patrol Plane Commander in World War II, an airline captain for many years with several major airlines, many years in general aviation, and *particularly* my experiences as a federal aviation safety inspector-investigator in an area plagued with airline disasters.

Since 1978, I have written several books on the politics of aviation safety in the United States, and other books on government intrigue that have certain common traits. I have appeared as guest and expert on over 3,000 radio and television shows since 1978. Also, I was one of the people that helped form the San Francisco chapter of SASI in the 1960s.

It was my hands-on experiences in the FAA that gave me an insight into serious problems that rarely see the light of day, and are almost never written about in safety journals. Among the reasons for this lack of exposure includes lack of knowledge of the inside problems, and for those who are aware of the very serious problems, they choose to remain silent.

Before describing some of the problems and the series of seemingly far-removed ripple effects, let me give you a few highlights on how I discovered and documented the safety problems related to a number of airline disasters as part of my official safety duties in the federal government.

After many years as a Navy and commercial pilot, I joined the FAA in the early 1960s as an air carrier operations inspector. At that time, airline crashes were occurring frequently, seemingly every few months. My official duties with the FAA included, for instance, conducting flight checks and issuing ratings to airline pilots and flight engineers; conducting investigations of airline incidents and accidents; looking for safety problems and safety violations; and making reports and recommendations to prevent accidents and incidents.

Among the many safety recommendations that I made included, for instance, (a) developing a procedure for avoiding high-altitude jet upsets when at that time the information available to the pilots was primitive; (b) promoting procedures to avoid inadvertent descent into the ground, the

cause of several major airline disasters; (c) promoting stall-recovery procedures to minimize the loss of altitude when stalls occur close to the ground; (d) identifying major safety problems such as dangerous high-sink-rate approaches long before that problem was addressed by government and the airlines; and recommending changes to prevent airliners from being hijacked.

My original assignment was to the FAA office in Los Angeles. During this assignment, I was asked to accept an assignment to correct the conditions responsible for the worst series of airline disasters in the nation's history at that time. Many of which were crashes involving United Airlines. I was told and assured, "Rod, this is a tough assignment, but we are right behind you." The first part of that statement was correct; the second part was totally incorrect.

After I became familiar with the airline's practices in my new assignment, after first being trained and rated in the DC-8 aircraft, I started discovering *why* the accident and near-accident rate was so high at that airline. I also discovered the culture in the FAA that prevented the federal government from acting on known safety problems, even when the problems were resulting in a series of fatal airline disasters.

Much of what I discovered was already known by other federal safety inspectors. Some of who admitted to me there was nothing they could do about it, and the only remedy was to either ignore the safety problems or transfer to another location where the problems were less serious. Here are a few examples of the safety problems that I discovered and reported, and which are shown in official government documents:

- Certain airline management personnel were denying to the cockpit crewmembers the recurrent training and competency checks that were industry standards and required by federal regulations. To cover up for these acts, they then falsified government-required records. In those days the training was done mostly in the aircraft, and cutting short the training-check flights saved the airline considerable money.
- Denying to the cockpit crew the yearly required emergency evacuation training, performing the training only every three years, and then falsifying government-required records to cover up for the violation. The government documents referring to this training clearly equated the hands-on completion of these matters with the lives, or the deaths, in survivable airline crashes. Compounding the violations of this important training, at that airline, was the fact that it was a DC-8 crash at Denver, of that *same airline*, several years earlier, that was the catalyst for the emergency training requirement.
- FAA approved company check airmen in the DC-8 program, where most of the senior pilots were located, routinely passed as satisfactory, senior captains whose performance was not only totally unsatisfactory, but actually dangerous.
- The widespread problem of pilots with high sink rate approach techniques, which was a dangerous practice and tolerated, with corrective training denied.
- Certain airline management personnel threatening federal safety inspectors that reported these problems and who attempted to exercise corrective actions as required by FAA directives. The airline's FAA-approved company check airmen threatened to have me transferred, as they bragged that they had done with my predecessor, when his reporting of the safety problems and violations angered key people at the airline.
- Numerous other safety problems.

Among the actions taken by certain FAA management personnel in response to these reported safety problems included, for example, the following:

- Warning inspectors not to make reports of safety problems, stating that the reports would

make the office (and them) look bad when there was an accident resulting from the problems. Of course, the function of these FAA people was to take actions on reported safety problems so that there would not be crashes occurring.

- Removing or destroying reports that were made of serious safety problems at the airline.
- Retaliating against inspectors who continued to make such reports, and against those inspectors who took legally-required actions against offending airline personnel.
- Refusing to order corrective actions for reported safety problems, despite the continued occurrence of fatal airline crashes.
- Ordering Inspectors not to observe the proficiency checks of certain senior captains known to have unsafe flying abilities.

Two World-Famous Airline Disasters Preceded my Assignment

Two of the many major United Airlines crashes that preceded my assignment to that crash-plagued airline included a DC-8 that crashed into Brooklyn on December 16, 1960, and a DC-8 that crashed a few months later at Denver. Both of these crashes resulted from the pilots' poor knowledge of the aircraft systems or aircraft operating procedures. These were obvious consequences from the training program problems that were repeatedly reported by government inspectors, and which FAA management refused to act upon.

Description of a Fatal Crash in my Area of Responsibility
That Was a Classic Cause-and-Effect Airline Disaster

One of the airline crashes that happened in my area of responsibility should be a standard cause-and-effect example included in most airline accident investigation or safety courses. That crash involved a United Airlines Boeing 727 that crashed at Salt Lake City in 1965, killing 43 people. Major facts behind that crash were withheld from the official accident report and from the public, thereby enabling the crash-causing problems to continue. *If* these problems had been addressed, especially the problems within the FAA, corrective actions would have been taken. And if they had been, the ripple effects in other air disasters most probably would not have occurred. As it relates to the FAA problems that prevented corrective actions to be ordered for known safety problems, it is highly probable that the 9/11 hijackings would not have occurred.

It is somewhat bizarre that from such seemingly remote problems, such major disasters could occur.

Mechanics of the Salt Lake City Crash and Deaths

The Salt Lake City crash was caused by the high sink rate approach, which resulted in the aircraft hitting the runway with such force that the landing gear was ripped off. As the aircraft slid down the runway on its fuselage, one or more fuel lines broke apart. The flight engineer-controlled fuel pump was not turned off during this slide, nor was the fuel valve turned off. This failure caused a large quantity of fuel to surround the aircraft and eventually ignite.

When the aircraft came to a stop, everyone was alive and unharmed. But due to poor evacuation procedures, 43 people perished. The Civil Aeronautics Board Bureau of Aviation Safety investigated the crash and issued a final report that stated the obvious direct causes of the crash and the loss of life:

- The pilot's high sink rate approach that caused the aircraft to crash.
- The flight engineer's failure to shut off the fuel pumps and fuel valves after impact, which led to the fire.
- The poor evacuation of the passengers by the crew, which led to the death of 43 people.

The Official Accident Report Was Not Entirely Honest

The board members omitted from that official accident report the misconduct that was

responsible for the deficiencies to exist. I had brought these serious matters to their attention *prior* to the crash. The official accident report omitted the following facts:

- The captain's high-sink-rate-approach was known to exist, and FAA management refused to the airline to provide him with corrective training. *I* had made a written report of *that captain's* high sink rate approach problems following an enroute flight check from Chicago to Denver via Omaha. I recommended that the captain receive additional training to correct that dangerous problem. Continuing their prior conduct in saving the airline money, FAA management refused to act on that safety problem, as they refused to act on *every other* safety problem that I and other inspectors reported at that airline with powerful political connections.
    - Compounding the high-sink-rate problems at that airline, after another enroute check flight, I stated to the captain that his high-sink-rate approach was not considered a safe procedure. The captain, a senior pilot at United Airlines, and ALPA officer at Seattle, complained to United Airlines. They in turn complained to the FAA regional office in Los Angeles, and I was removed from inspection duties for several weeks.
- The flight engineer's failure to shut off the fuel booster pumps and fuel valves would be a product of poor training and low proficiency standards. I had *repeatedly* reported the flight engineer training at that airline to be the worst that I had seen in my several decades in military and commercial aviation. I reported that many of the flight engineers did not meet industry standards or the FAA standards, due to the method of training and the absence of a meaningful competency check. In response to a five-page report detailing the flight engineer training shortcomings, FAA management responded with a memo stating I had a personality conflict. These training and competency check problems undoubtedly played a key role in why the flight engineer did not perform the steps that the board's accident report stated he should have taken.
- The poor evacuation of the passengers that led to 43 deaths would also be an end product of a deficient training program. Prior to the Salt Lake City crash, I had made two written reports stating that the airline was not performing the emergency evacuation training every year, as the law required, and that they were doing it only every three years, and then falsifying the records. Making this violation even more outrageous was the fact that the strongly worded requirement clearly equated the compliance or non-compliance with the lives, or the deaths, in survivable crash. Even worse, it was the United Airlines DC-8 crash at Denver that was the catalyst for that strongly worded emergency evacuation training requirement.

Prior Knowledge of Serious Problems by Board Members

Prior to the Salt Lake City crash, I had notified certain people in the CAB Bureau of Aviation Safety of the problems in the FAA and at that airline, and warned of the continuation of fatal crashes from these serious matters. In response to my first telephone contact, a well-known member of the board at that time admitted to me that he *already* knew about the problems, that my predecessor on the program told him about them several years earlier.

That prior knowledge was conveyed to him either shortly before or shortly after the United Airlines DC-8 crashed into New York City on December 16, 1960, and the fatal United Airlines DC-8 crash at Denver.

Both of those crashes were due to gross pilot errors, and obviously the result of the denial of legally required training, the anything-goes competency standards, the FAA management obstruction of corrective actions, and the failure of others who *knew* of these problems to speak out.

The Continuing Safety Outrages Forced Me to Take Unprecedented Actions

After exhausting various measures trying to halt these outrageous problems, which included notifying higher FAA management and CAB board personnel, none of whom responded, I took an action that had never before happened: I exercised the law in such a way that I acted similar to an independent prosecutor. In this capacity, I conducted hearings for several weeks in court-like proceedings, during which I obtained the testimony of key FAA management, and obtained additional documents to prove my charges that several prior fatal airline crashes occurred because of misconduct within the FAA.

Serendipitous Finding of a Report of Additional Falsified Training Flights

During the hearings, by accident, I discovered a prior document that was in the possession of the FAA legal counsel. That document was prepared shortly *before* the DC-8 crash into New York City. It showed that certain key people at the airline were routinely depriving the cockpit crewmembers of the legally required training and then falsifying government-required documents to cover up for this serious matter.

This discovery was made after several FAA inspectors from the Denver office traveled to the United Airlines maintenance base at San Francisco to examine aircraft maintenance logs. It was discovered, as they previously suspected, that aircraft used for training and competency check flights had not been airborne long enough to accomplish the required maneuvers.

These practices explained why crewmembers in several prior airline disasters had used such poor judgment with such catastrophic fatal consequences. Combined with what *I* discovered several years later, these practices had continued, with the knowledge of FAA management. These were serious findings and withheld from the official accident reports and the lawyers for the next-of-kin.

Three Additional Fatal Crashes Occurred During the FAA Hearings

During the hearings that I conducted in Denver, three *additional* fatal airline disasters occurred. Each one was caused by the same problems I had reported in writing, for which FAA management blocked corrective actions. These three crashes included (a) the United Airlines Salt Lake City crash that I had previously mentioned; (b) a United Airlines crash into Lake Michigan with heavy loss of life, caused by the same lack of altitude awareness that I sought to correct and was ordered to cease my corrective actions; and (c) an American Airlines crash during approach to Cincinnati, due to same lack of altitude awareness,

My Closing Brief Warned of the Consequences of a Cover-Up

At the end of the hearings, I submitted a closing brief. That closing brief warned that if a cover-up occurred in the hearing decision that the safety misconduct within the FAA would continue, as would the ripple effects in crashes and deaths. And that is what occurred, as the FAA lawyer, William Jennings, on the FAA administrator's staff, acting as hearing officer, covered up for the hard evidence of corrupt activities within the FAA and by certain people at United Airlines.

I made CAB board members aware of these matters by letters. Shortly thereafter as the National Transportation Safety Board (NTSB) came into being, I made board members aware of these continuing problems. No known actions were taken, which is common in the government of the United States.

As I forewarned, and as could be expected, the preventable airline disasters continued to occur, not only at United Airlines, but also in other areas where the standard FAA obstruction with addressing safety problems resulted in preventable air tragedies. I will address just one of these before I get to the ripple effects that made possible the hijackings of four airliners on 9/11.

One of Many Subsequent Ripple-Effect Air Disasters

A United Airlines DC-8 crashed into Portland, Oregon, in 1978, and was an obvious ripple

effect from thee serious safety problems that I repeatedly reported. The Portland crash started with the failure of one of the landing gear lights to illuminate as the United Airlines DC-8 approached Portland for a landing. Despite the procedure for making a visual inspection to determine the landing gear was down and locked, the crew did not understand or know how to follow the proper procedure. That problem was compounded by the captain's failure to understand the danger after the flight engineer warned him that they were extremely low on fuel.

The first edition of my book, *Unfriendly Skies*, had been released shortly before that crash, and the NTSB board members, possibly fearing that their prior knowledge of the problem and refusal to act would be exposed if a public hearing was held, did the unprecedented: they refused to conduct the usual public hearing that would have shown their complicity in the conditions that made that crash possible. By covering up, again, they enabled the culture within the FAA to continue, along with the crashes, including the 9/11 hijackings.

One consequence of that crash was CRM, called either cockpit resource management or crew resource management. But the problem *wasn't* failure of the crew to speak out; the problem was *ignorance* by the entire crew, resulting from the repeatedly reported serious training program problems and FAA management refusal to act on the reports.

A Quick Analysis of the FAA's Blame in the Hijackings of Four Airliners on September 11, 2001

Having given a few highlights on what goes on in the FAA, let's look at how this deep-seated culture, and the failure of FAA management to act on the continuing airline hijacking problems, had ripple effects on 9/11. Let's start with a few basic facts:

- It was the FAA, not the FBI or CIA, that had the primary responsibility to order the measures necessary to prevent airliners from being hijacked.
- Hijackings worldwide had been occurring for years, so FAA personnel were not unaware of the dangers.
- The FAA was receiving almost daily warnings of terrorists' plans to hijack airliners.
- The FAA knew of the attempt to hijack a French airliner and fly it into the Eiffel Tower in Paris.
- FAA personnel knew the measures that had to be taken to prevent airliners from being hijacked. I made such a recommendation years earlier, which was ignored, just as every other recommendation was ignored.
- One of the most obvious measure to prevent airliners from being hijacked, that could have been implemented nationwide, overnight, was removal of the cockpit door keys from the cabin flight attendants. The evidence strongly indicates that cockpit-door keys were used to gain entry to the cockpit of each of the hijacked aircraft. Almost any male can easily take these keys from the female cabin flight attendants. I doubt that any attempt by the terrorists to break down the cockpit doors played a role in taking over the aircraft. If anyone had tried breaking down the door to the cockpit, the average pilot would put the aircraft into an unusual attitude, resulting in a halt to such efforts. The evidence indicates that the pilots were suddenly confronted with the terrorists, suggesting entry by use of the cockpit door key.
- The answer to *why* the obviously needed known procedures to prevent hijackings were never ordered was the culture that I and other inspectors had discovered, which had been responsible for many *prior* crashes due to known safety problems, including hijackings.

Several Possible Reasons Why the Primary Areas of Blame for the 9/11 Hijackings Was Avoided by Congress and the 9/11 Commission

An investigation into the conduct of the people that had the primary responsibility for preventing airliners from being hijacked, obviously the FAA, would risk exposing the large amount of evidence of FAA management misconduct. This would include the charges that I made and documented during the period when I acted similar to an independent prosecutor. Such an examination would have revealed, for instance:

- The pattern of misconduct by FAA management that repeatedly blocked the actions of the professional air safety inspectors-investigators, with a string of fatal consequences.
- The pattern of repeatedly blocking the implementation of measures addressing known safety problems that had already resulted in fatal crashes.
- The pattern of retaliating against federal safety inspectors who report safety problems that required FAA management to take action, including action against airlines with strong political connections.
- The many efforts to report these problems by different inspectors, including my actions. Out of desperation, I had filed federal actions under the two federal statutes seeking to report the federal offenses associated with several major airline disasters. These two statutes are the federal crime reporting statute, Title 18 U.S.C. Section 4, which requires anyone knowing of a federal crime to report it to a federal judge or other federal officer; and Title 28 U.S.C. Section 1361, that permits any citizen to file a federal action seeking to obtain a court order for a federal official to perform a mandatory duty and to halt actions that violate the law. Further misconduct would have been revealed if the hearings got to these matters.

Cover-Up by the 9/11 Commission

The 9/11 Commission blamed the hijackings of four airliners on *failures* of the FBI and CIA to act on evidence of the hijacking *scheme*. Blaming the hijackings and 3,000 deaths on the more innocent sounding failures of the FBI and CIA was more politically acceptable than addressing the hardcore misconduct within government and the widespread cover-up of that misconduct.

Before the 9/11 Commission issued its report, I brought these matters to the 9/11 Commission via two declarations, neither of which was acknowledge or referred to. Since I was at the center of the group that held the responsibility for preventing airliners from being hijacked, and because of my documentation of the misconduct that would explain why the FAA failed to act to prevent hijackings, my information would be of primary importance for addressing the problems that enabled the terrorists to hijack four airliners.

Problems Discovered in Other Areas of Government Conduct

During the years that I sought to make these problems known, from my books and my radio and TV appearances, many other former and present government agents contacted me, providing me with information on misconduct in various government offices. My initial efforts over the years had been focused on the problems in the aviation sectors, and brought current by other FAA personnel. But the dozens of other insiders who wanted to make known what they discovered included people from other government entities, including the FBI, DEA, Customs, INS, Secret Service, CIA, and others. This information suggested that the problems in the government's aviation safety offices in the United States could also be found in other areas of government operations, and is a deep-seated culture.

What I have stated in this paper are only the highlights. More information can be found in two books that I wrote addressing these matters: *Unfriendly Skies: 20th and 21st Centuries*, and *Blowback, 9/11, and Cover-Ups*. Both are available from Amazon.com. These are non-profit books written to circumvent the cover-ups and the failure of those who knew of the problems and who

lacked the courage to speak out.

There can be no excuse for failure of anyone in ISASI to be concerned about these statements, and for those who can do so, to speak out and demand a prompt and meaningful investigation. Obviously, if my statements are true, powerful people and powerful groups will block any meaningful investigation. It is of utmost importance that my extensive documentation be carefully examined and made available to ISASI members outside of the United States.

I have paid a very heavy price for attempting to address these serious matters that continue to exist. Even though airline crashes are today, few and far between, certain deep-seated problems exist that enable certain air disasters to occur that would not otherwise have occurred. That certainly applies to the hijacking of four airliners on 9/11, which not only killed nearly 3,000 people, but also initiated events that have become even more catastrophic. Only by understanding insider knowledge can anyone recognize all of these catastrophic events as being made possible by the ripple effects of what has been stated here.

There are many good people in the government's aviation safety offices, but the misconduct of a few in key positions have undermined the government's aviation safety responsibilities.

Many people do not want this information to become known, being more interested in protesting certain people or groups than in revealing the truth. It is people like them that have enabled these arrogant conditions to exist, and the deadly consequences to occur.

Today, ISASI is not solely a U.S. group, but an international group, though its leadership includes people with prior relationship to the FAA. As a leader in accident investigation and promotion of aviation safety, and as stated in its Code of Ethics and Conduct, ISASI is duty bound to investigate these matters. As a founding member of the San Francisco chapter, and a member of ISASI, I have a responsibility to make other members of the group aware of these matters.

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