THE BUFFALO NEWS

PRINT THIS

Awaiting Flight 3407 report, families plan for walk

Emotions convergingas anniversary nears

By Jerry Zremski
NEWS WASHINGTON BUREAU CHIEF
Updated: January 27, 2010, 7:12 am /
Published: January 27, 2010, 12:30 am

WASHINGTON — Federal investigators plan to release their report on the crash of Continental Connection Flight 3407 next week, while relatives of the crash's victims are gearing up to mark its one-year anniversary Feb. 12 by walking from the Clarence Center accident site to Buffalo Niagara International Airport in Cheektowaga.

The National Transportation Safety Board has scheduled a 9:30 a. m. meeting Tuesday to approve and release the report. For the families, that will be the start of an emotional 10 days leading up to the anniversary.

More than 50 members of the Families of Continental Flight 3407 plan to attend the safety board meeting, said Scott Maurer of Moore, S. C., whose daughter, Lorin, was killed in the crash. Others will gather in the Millennium Hotel, 2040 Walden Ave., Cheektowaga, to view the proceedings.

Family members, loved ones and friends will take part in the Feb. 12 walk, which is intended to honor the victims and to call attention to the air safety lapses that have not been addressed in the wake of the crash.

Fifty people died when the Continental Connection flight from Newark,

N. J., plummeted into a house in Clarence Center on that icy night last year.

Investigators are not discussing details of the report, but many key findings have trickled out in the year since the crash.

Pilot training and fatigue are expected to emerge as key factors behind the accident, which led the Federal Aviation Administration to initiate a "Call to Action" urging airlines to voluntarily boost safety efforts..

The FAA released its "Call to Action" report Tuesday, and it mainly repeated previous announcements the agency had made on aviation safety.

But in a speech to the Aero Club of Washington, FAA Administrator Randy Babbitt acknowledged how much more needs to be done—particularly with regard to pilot training.

"We know we need to re-examine pilot qualifications to make sure commercial pilots who carry passengers have the appropriate operational experience," Babbitt said. "They need to be trained for the mission they are flying."

The Flight 3407 families have been pushing a requirement that co-pilots, like pilots, have 1,500 hours of flying experience before they are hired.

Babbitt previously expressed skepticism about that idea, but he sounded more open to it during his speech Tuesday.

"There are proposals that raise the number of required hours, and we need to look at that possibility," he said. "But we must have qualification and training requirements that elevate the importance of mission-appropriate experience."

The FAA is planning to issue a revised set of pilot training rules early this year.

In addition, this spring the agency will release a proposal for new rules setting limits on pilot flight time and duty time.

Babbitt had targeted that proposal, aimed at combating pilot fatigue, for release by the end of 2009. He said he had set "an overly ambitious schedule" for its release.

With his speech and the release of the Call to Action report, Babbitt appeared to be trying to get out in front of a wave of publicity about airline safety that's likely to ensue with the release of the accident report and culminate with the crash anniversary.

John Kausner of Clarence, whose daughter Elly died in the accident, is organizing the crash anniversary walk with Maurer's help.

Details are still being worked out, and it's unclear how many family members will make the 10-mile walk and exactly who will accompany them.

But Maurer said it's a fitting way to honor the victims on the anniversary of their deaths.

"All of our loved ones were coming to Buffalo for some specific reason, and they didn't finish the trip," Maurer said. "We thought we would complete the journey for them, to do that in honor of our loved ones."

The walk will culminate with a news conference in which the families will continue to push for federal legislation mandating that co-pilots have a minimum of 1,500 hours of experience, up from 250 today.

Kausner acknowledged that a 10- mile walk in the Buffalo area's February weather could be a challenge, and he said the group is making contingency plans if there's a big snowstorm.

"But unless it's a Jimmy Griffin sixpack day, I'm walking," Kausner said, referring to the late Buffalo mayor's suggestion that people "stay inside, grab a six-pack and watch a good football game" during the Blizzard of 1985.

In addition to the walk, Robin Tolsma, who lost her husband, Darren, in the crash, is organizing an effort called "To Light the Way Home," urging local residents to leave their porch lights on the anniversary of the crash in honor of its victims.

jzremski@buffnews.com

Keith Radford

From: WKBW TV - Buffalo
Sent: Friday, January 29, 2010 12:41 PM
To: Keith Radford
Subject: FW: Tues - Flight 3407 Buffalo Families' Attorney on NTSB Report on Cause of Crash

---

From: Susan Roth [mailto:prsue@rothpr.com]
Sent: Fri 1/29/2010 12:29 PM
To: WKBW TV - Buffalo
Subject: Tues - Flight 3407 Buffalo Families' Attorney on NTSB Report on Cause of Crash

CELL 917-834-295

CONTACT: Susan Roth, 301-530-3539, 202-997-5672 (c), prsue@rothpr.com

Jay Winuk, 845-277-1160, 914-523-3227 (c), jay@winukpr.com (main contact on Tuesday after 4 p.m. ET)

INTERVIEW AVAILABILITY - James P. Kreindler, Chairman of the Flight 3407 Plaintiffs Committee representing the families of the victims of the crash along with partner Justin Green, on Tuesday in Washington DC at NTSB hearings announcing determination of the cause of the crash that killed 50 people on Feb. 12, 2009. Also available earlier in New York or by phone.

PENDING NTSB REPORT ON THE CAUSE OF THE FEB 12, 2009 CRASH OF CONTINENTAL CONNECTION FLIGHT 3407 NEAR BUFFALO:

AVIATION AND LEGAL EXPERTS AVAILABLE TO COMMENT ON SITE IN DC AND IN ADVANCE OF NTSB REPORT

"It is clear to us that systematic failures in pilot hiring, scheduling and training lead to the gross pilot errors that caused the crash of Flight 3407 outside of Buffalo on February 12, 2009," says James P. Kreindler, chairman of the Flight 3407 Plaintiffs Committee representing the families of the victims of the crash. "We believe that the NTSB hearing next week will shine a spotlight on the failures of Colgan Air, and hope that the NTSB will not permit Colgan to simply blame their two deceased pilots and thus allow the company to continue its business as usual. Colgan and the entire regional airline industry need to substantially change their business practices to prevent future tragic crashes."

The National Transportation Safety Board (NTSB) will announce in Washington, DC, on Tuesday, February 2, 2010, its determination of the cause(s) of the crash of Flight 3407, which killed 50 people when the plane went down outside of Buffalo on February 2, 2009. The aviation attorneys and pilots of Kreindler & Kreindler LLP, which represents 18 of the victims' families and is the nation's leading aviation law firm (www.kreindler.com), are available to help you interpret the many legal and investigative issues of this crash and advise about the status of litigation.

"There is a shockingly dangerous corporate culture inherent in some segments of the airline industry today which places more concern on revenue than safety," says Kreindler partner and military-trained pilot Justin T. Green. "In our view, Continental Airlines, which outsourced this commuter flight to

Colgan, shares responsibility with Colgan for the deaths of these victims. The victims who were passengers bought their tickets from Continental Airlines, and their families will not permit the airline to walk away from its responsibility for the Continental Connection Flight 3407 disaster."

Mr. Kreindler and Mr. Green will be at the NTSB hearings in DC next week and are available to discuss with you in advance and on site the status of the 3407 litigation, analysis of the pending NTSB report, victims' rights, crash investigation procedures and more. Their bios are pasted and linked below. Please let me know if you are interested in speaking with Mr. Kreindler and/or Mr. Green.

Additional info: Kreindler's aviation experts have produced an informative **animated simulation which chronologically reconstructs the flight path and descent of Flight 3407.** Simulation available here: http://kreindler.com/kreindler_news/news_current/flight-3407-video.html

Additional investigative information and expert opinions are available here: http://kreindler.com/kreindler_news/news_current/2-13-2009-Buffalo-New-York-Continental-Express-Flight-3407-Crash.html . (Justin/Jim: Is this write-up up-to-date?)

Expert Bios:

James P. Kreindler, Law Partner

http://www.kreindler.com/biographies/partners/james_kreindler.html

Mr. Kreindler is chairman of the Flight 3407 plaintiffs committee representing the families and estates of the victims of the crash. He served as co-chair of the 9/11 Plaintiffs' Committee suing terror financiers and supporters, and helped lead the Plaintiffs' Committee in the Pan Am 103 families' suit against Libya for the disaster over Lockerbie, Scotland. He has played a major role in many notable airline disaster cases, including the EgyptAir 990 crash on October 31, 1999 (member of the Executive Committee of the Plaintiffs Steering Committee); the Swissair Flight 111 disaster near Peggy's Cove, Nova Scotia on September 2, 1998 (serving as a Plaintiffs' Committee member); and the TWA Flight 800 disaster off Long Island, New York (appointed a member of the Plaintiffs' Committee).

Justin T. Green, Law Partner

http://www.kreindler.com/biographies/partners/justin_green.html

As an aviation lawyer, Mr. Green has litigated dozens of major aviation cases, including wrongful death cases that arose from the following crashes: U.S. Air Force CT-43 (Boeing 737) in Croatia, carrying Commerce Secretary Ron Brown, September 11, 2001 terrorist attacks, SwissAir Flight 111 and EgyptAir Flight 990. Mr. Green is a Persian Gulf War veteran; he served in the United States Marine Corps as an attack helicopter pilot and aviation safety officer, responsible for his squadron's flight safety and for investigating aviation accidents. He is a 1990 graduate of the Aviation Safety Program at the Naval Postgraduate School in Monterey, California. He holds a commercial license from the Federal Aviation Administration in airplanes and helicopters, and he is instrument-rated in both. He has flight time in many different aircraft, including aircraft manufactured by Bell Helicopter, Inc., Cessna Aircraft Company, Sikorsky Helicopter and Piper Aircraft, Inc.

Keith Radford

From: Bob Dingwall
Sent: Friday, January 29, 2010 9:03 PM
To: Keith Radford; Scott MacDowell
Subject: FW: NTSB TO MEET ON FINAL REPORT ON COLGAN AIR DASH-8 ACCIDENT NEAR BUFFALO, NEW YORK
Importance: High

FYI

From: Schoenholtz, Howard D [mailto:Howard.D.Schoenholtz@abc.com]
Sent: Fri 1/29/2010 2:49 PM
To: Bob Dingwall
Cc: Teitel, Rebecca; Scott, Michael W
Subject: FW: NTSB TO MEET ON FINAL REPORT ON COLGAN AIR DASH-8 ACCIDENT NEAR BUFFALO, NEW YORK

From: NTSB_News [mailto:NTSB_NEWS@LISTSERV.NTSB.GOV] **On Behalf Of** NTSB Press Releases
Sent: Friday, January 29, 2010 2:44 PM
To: NTSB_NEWS@LISTSERV.NTSB.GOV
Subject: NTSB TO MEET ON FINAL REPORT ON COLGAN AIR DASH-8 ACCIDENT NEAR BUFFALO, NEW YORK

****
NTSB ADVISORY
****

National Transportation Safety Board
Washington, DC 20594

January 29, 2010

****

NTSB TO MEET ON FINAL REPORT ON COLGAN AIR DASH-8 ACCIDENT
NEAR BUFFALO, NEW YORK

****

The National Transportation Safety Board will hold a Board meeting on **Tuesday, February 2, 2010, at 9:30 a.m.** in its Board Room and Conference Center, 429 L'Enfant Plaza, S.W., Washington, D.C. The Board will consider a final report on the following investigation:

On February 12, 2009, a Colgan Air, Inc., Bombardier DHC-8-400, N200WQ, operating as Continental Connection flight 3407, was on an instrument approach to Buffalo-Niagara

International Airport, Buffalo, New York, when it crashed into a residence in Clarence Center, New York, about 5 nautical miles northeast of the airport. The 2 pilots, 2 flight attendants, and 45 passengers aboard the airplane were killed, one person on the ground was killed, and the airplane was destroyed by impact forces and a postcrash fire. The flight was a 14 Code of Federal Regulations (CFR) Part 121 scheduled passenger flight from Newark, New Jersey. Night visual meteorological conditions prevailed at the time of the accident.

A live and archived webcast of the proceedings will be available on the Board's website at http://www.ntsb.gov/events/Boardmeeting.htm. Technical support details are available under "Board Meetings" on the NTSB website. To report any problems, please call 703-993-3100 and ask for Webcast Technical Support.

A summary of the Board's final report, which will include findings, probable cause and safety recommendations, will appear on the website shortly after the conclusion of the meeting. The entire report will appear on the website several weeks later.

Verizon wireless cellular service is accessible in the Board Room and Conference Center.

Directions to the NTSB Board Room: Front door located on Lower 10th Street, directly below L'Enfant Plaza. From Metrorail, exit L'Enfant Plaza station at 9th and D Streets escalator, walk through shopping mall, at CVS store (on the left), take escalator (on the right) down one level. The Board Room will be to your left.

NTSB Media contact: Keith Holloway
202-314-6100
hollowk@ntsb.gov

****

BOARD MEETING
FEBRUARY 2, 2010

Aircraft Accident Report

Crash on Approach to Airport Colgan Air, Inc. Operating as Continental Connection Flight 3407 Bombardier DHC-8-400, N200WQ Clarence Center, New York February 12, 2009

Agenda for the Board Meeting on

Loss of Control on Approach, Colgan Air, Inc., Operating as Continental Connection Flight 3407, Bombardier DHC-8-400, N200WQ Clarence Center, New York, February 12, 2009

February 2, 2010

I.	**Opening Statement**	Tom Haueter
II.	**Investigator-in-Charge Statement**	Lorenda Ward
III.	**Crew Response to Stick Shaker and Stall** **Monitoring Failures** **Airspeed Selection Procedures** **Stall Training**	Dr. Evan Byrne Capt. Roger Cox
IV.	**Pilot Training Records, PRIA, and Remedial Training Programs**	Capt. Roger Cox
V.	**Pilot Professionalism**	Dr. Evan Byrne
VI.	**Commuting and Fatigue**	Dr. Evan Byrne
VII.	**Flight Operational Quality Assurance** **FAA Oversight and SAFO Process**	Capt. Roger Cox

Seating Chart for the Board Meeting on

Loss of Control on Approach, Colgan Air, Inc., Operating as Continental Connection Flight 3407 Bombardier DHC-8-400, N200WQ, Clarence Center, New York, February 12, 2009

February 2, 2010

The Board

Dr. David Mayer Managing Director	Tom Haueter Director, Office of Aviation Safety	Lorenda Ward Investigator-in-Charge	Dr. Evan Byrne Human Performance Group Chairman	Capt. Roger Cox Operations Group Chairman	Dr. Kevin Renze Aircraft Performance Group Chairman
Tom Zoeller Executive Officer	Gary Halbert General Counsel	Dr. Joe Kolly Director, Office of Research and Engineering	Karen Stein Report Writer	Scott Warren Systems Group Chairman	Jeff Marcus Office of Safety Recommendations and Advocacy
Don Eick Meteorology Group Chairman and Visuals	Jennifer Bishop Chief, Writing and Editing Division and Timer	Dr. Dan Bower Chief, Vehicle Performance Division	Dennis Crider Simulator Fidelity		

Good morning. The Aviation Staff is pleased to present to the Board the report on the accident involving Colgan flight 3407 near Buffalo, New York.

This investigation was very detailed, and there were numerous issues identified and thoroughly examined during the investigation. In the report, staff is proposing 23 safety recommendations to the FAA in the areas of prevention of flight crew monitoring failures, pilot professionalism, fatigue, remedial training, pilot training records, airspeed selection procedures, stall training, FAA oversight, flight operational quality assurance programs, the use of personal portable electronic devices on the flight deck, the FAA Safety Alert for Operators process, and weather information dissemination. However, there are two issues that are not fully addressed in the draft report. These issues are Professionalism and Code-sharing agreements. Because these issues go beyond the Colgan accident, staff believes that additional fact finding is necessary

In previous accident and incident investigations, staff has noted issues regarding professionalism with both pilots and air traffic controllers. Professionalism issues are not limited to specific airlines, hours of experience, salary, or even the nature of the job and can be as insidious as fatigue in leading to accidents and incidents. Staff has recommended, and the Board has approved, holding a forum on Pilot and Air traffic controller professionalism.

Because Colgan was involved in a code-sharing arrangement with Continental Airlines, staff examined issues associated with airline code-sharing and the complexities of code-sharing agreements. In some cases, code-sharing allows a major carrier to expand its routes to airports that would otherwise not be profitable. In other cases, code-sharing allows a smaller carrier access to a major carrier's reservation and marketing system. Code-sharing involves both domestic and international carriers and is often invisible to the public. Because code-sharing issues are so broad and go beyond this accident, staff has recommended that the Board hold a symposium later this year to explore in detail the issues involved with code-sharing arrangements.

Completing this report in less than one year required considerable staff resources, not only because of the complexity of the accident, but also because there were other investigations that

required staff's attention. (The deleted sentence basically restates the previous sentence.) For instance, last year, our operations and air traffic investigators, a total of 7 people, worked a combined 101 investigations, accumulated 349 days on travel, and logged about 1700 hours in overtime. Since the Colgan accident, the Aviation staff has:

- Completed 5 major reports
- Held 4 Public Hearings, including one for the Colgan accident
- Launched on 2 major accidents
- Launched on 153 regional accidents
- Launched on 9 foreign accidents
- Issued 127 safety recommendations

In the coming year, the aviation staff is on track to deliver 7 additional major reports to the Board.

Staff's work on the Colgan investigation will not end with today's Board meeting, as we will continue to push for the implementation of the safety recommendations that the Board adopts today.

Investigator-in-Charge Presentation
Colgan Board Meeting

Good morning Chairman Hersman, Vice-Chairman Hart and Member Sumwalt.

On February 12, 2009, about 2217 eastern standard time, a Colgan Air, Bombardier Dash 8-Q400, operating as Continental Connection flight 3407, was on an instrument approach to Buffalo-Niagara International Airport, Buffalo, New York, when it crashed into a residence in Clarence Center, about 5 nautical miles northeast of the airport. The 2 pilots, 2 flight attendants, and 45 passengers aboard the airplane were killed, one person on the ground was killed, and the airplane was destroyed by impact forces and a postcrash fire.

Variable periods of snow and light-to-moderate icing were expected during the accident airplane's approach to BUF. Because of the expected weather, during the climb out of Newark to their cruising altitude, the captain (who was the flying pilot), set the reference speeds switch to the increase position, which was appropriate for the flying conditions. For the Q400, turning the reference speed switch from the off to increase position lowered the angle-of-attack reference for the stick shaker activation and raised the position of the low-speed cue on the pilots' indicated airspeed displays by 15 knots. This action ensured that the airplane would have the same, or greater, performance margins relative to the stall speed while operating in icing conditions as long as the landing airspeeds were appropriately increased to remain above the stall warning threshold.

The first officer, who was the monitoring pilot, obtained the landing airspeeds for non-icing conditions. She did not enter the keywords that would indicate the flight was in icing conditions, therefore the mismatched landing speed of 118 knots that the flight crew set was 13 knots below the stick shaker activation speed of 131 knots.

When the airplane reached 131 knots, the stick shaker activated and the autopilot disengaged. A review of performance data indicated that the airplane was not close to an actual stall because the airplane had minimum ice accretion but the flight crew was unaware of that fact. The captain reacted to the stick shaker by pulling back on the control column and applying power short of the rating detent. Pulling back on the control column increased the angle-of-attack, pitch, and load factor, causing the airplane to enter an accelerated stall.

During the stall sequence, the stick pusher fired three times to decrease the angle-of-attack. However, after each activation, the captain continued to pull back on the control column, which exacerbated the airplanes' stalled condition and prevented a potential recovery.

A similar animation of the last 2 minutes of the accident flight was shown at the public hearing will be shown again to orient the audience.

The top half of the screen shows the three-dimensional model of the airplane and its motion.

Superimposed over the model is CVR text. Time is shown in the middle of the screen on the right side.

The bottom half of the screen depicts a set of instruments and indicators. Moving from left to right:

- Airspeed (in text, boxed in red during low speed), airspeed tape, low speed cue [in red next to the

airspeed tape], attitude indicator showing pitch and roll attitude, altitude (in text), altitude tape, rate of climb, and heading (in text).

- Stall protection system - Stick pusher and stick shaker (indicated as text that turns to YELLOW when the systems activated), control wheel/control column icon depicting the control wheel (rotating right or left) and control column (moving up or down), and an indicator showing rudder pedal inputs.

- Indicators for the power lever, condition lever, and the flap handle are to the far right. Autopilot status and landing gear handle position are indicated as text.

The team was on-scene for 8 days documenting the wreckage, conducting interviews, and collecting records related to the accident flight, airplane and crew.

Three months later, a 3 day en banc public hearing was held in Washington, DC with former Acting Chairman Mark Rosenker presiding over the hearing. The safety issues discussed at the hearing were the effect of icing on airplane performance, cold weather operations, sterile cockpit rules, flight crew experience, fatigue management and stall recovery training.

Early in the investigation we were able to identify that:
The flight crew and the airplane were properly certificated. No evidence of any pre-impact structural, engines or systems failures. ATC was not a factor in the accident. The accident was not survivable.

The weather on the night of the accident was typical for the Buffalo area and the time of the year, and the ice accumulation did not affect the ability of the flight crew to fly and control the airplane. Although weather did not affect the performance of the airplane it is important for flight crew members to have complete and accurate weather documents

to assist them in their pre-flight and in-flight decision making, and staff has proposed a recommendation in that area.

Also, staff is recommending a change to icing definitions to include accretion rates and specific pilot actions that would help pilots more accurately determine the icing conditions to report in PIREPS and more effectively respond to those conditions.

Because staff was able to rule out several factors in this accident, this investigation focused on human performance and operational factors, and all of the presentations and the majority of the recommendations fall into those categories.

We'll start with a discussion of the flight crew's response and their monitoring failures. Followed by: airspeed selection procedures for landing and in icing conditions, stall training, including the difference between wing and tailplane stalls, training records and remedial training programs, to include discussion on the captain's disapprovals,

Pilot professionalism to include discussion on sterile cockpit, leadership training, and use of personal portable electronic devices, fatigue and commuting, and finally, we will look at Flight Operational Quality Assurance, or FOQA, programs, and FAA oversight and its process for transmitting safety-critical information by SAFOs.

Before we start the presentations I would like to thank former Board Member Steven Chealander, who was the Board Member on scene, and all the NTSB investigators and staff who have supported the accident investigation.

Parties to the investigation were: the Federal Aviation Administration, Colgan Air, Air Line Pilots Association, National Air Traffic Controller Association, and the United Steelworkers Union.

As the state of design and manufacture for the airplane and engines, the Transportation Safety Board of Canada participated in the investigation. The Canadian accredited representative was assisted by technical advisors from Transport Canada, Bombardier, and Pratt and Whitney Canada.

As the state of manufacture for the propellers, the Aircraft Accident Investigation Branch - United Kingdom also participated.

In closing, I would also like to thank the numerous state, local and federal agencies that were not parties to the investigation but played an important role in assisting our team with our on-scene activities.

Madam Chairman, this concludes my presentation and if there are no questions, Dr. Byrne is ready to begin his presentation on flight crew's response and monitoring failures, followed by Captain Cox's presentation on airspeed selection and stall training.

NATIONAL TRANSPORTATION SAFETY BOARD
"Sunshine" Meeting
February 2, 2010

Good Morning. My name is Debbie Hersman and it is my privilege to serve as the Chairman of the National Transportation Safety Board. I would like to take a moment to introduce my colleagues: Vice Chairman Chris Hart, and Board Member Robert Sumwalt.

Welcome to the boardroom of the National Transportation Safety Board. Under the 1976 Government in the Sunshine Act, multi-member federal agencies conduct much of their business in open session. Therefore, Board meetings are often called "Sunshine" meetings. While the public is invited to observe the meeting, only the Board Members and NTSB staff will participate in today's discussions.

Before we begin, I would like to take a moment to make a few comments. First, I would like to recognize a former Board member, Steve Chealander, who is joining us in the audience today. Steve served on the Safety Board from 2007-2009 and lead the Safety Board's go-team to the accident and was the on-site

spokesperson. We are grateful to Steve for his tireless advocacy on behalf of the travelling public, and I am so pleased he could be here with us in the boardroom as we complete our investigation and issue our recommendations.

On behalf of the Board, I would also like to extend my appreciation to the nearly sixty organizations and scores of individuals who helped with this investigation – these include representatives from state and federal agencies, area-wide county and city offices, emergency responders, police departments, service organizations and so many others. This accident investigation involved an uncommonly large support team – whether it was helping with the rescue and recovery operations, support efforts or with the overall investigation, your tireless work and cooperation were invaluable. Thank you.

I also want to acknowledge the family members and friends of those who lost their lives on Continental Connection flight 3407. Over 50 family members and friends are with us in our audience today, and many others are watching at remote viewing locations in Buffalo, NY and Elizabeth, NJ, and via webcast. On behalf of the men and women of the National Transportation Safety Board, please accept our sincere condolences for your loss and for what you have endured since the accident.

Our meeting today is being held to determine the probable cause of this accident and to consider safety recommendations so that accidents, like this one, do not happen again. We are aware that, over the past year, many of the family members and friends, individually and collectively, have advocated tirelessly to promote aviation safety. We are encouraged by your efforts, and want to assure you that the Safety Board is also committed to preventing similar tragedies.

We convene today – within the one year anniversary of this accident. Concluding any investigation within one year is challenging and, in fact, it has been over 15 years since we've both held a public hearing and completed a major investigation in less than one year. I made a commitment to those who lost loved ones that the Safety Board would aggressively investigate this accident. While the Board members sit up here on the dais today, it is the staff who have done the work to produce this comprehensive report. On behalf of the other Board Members, I thank you, staff, for your dedication and commitment in holding an excellent public hearing last May, and concluding the investigation and presenting the accident report for our consideration – in less than one year.

The conclusions, probable cause, and recommendations we will discuss today are based on the facts of this particular investigation. In other words, the scope of the accident report is defined by facts obtained during the investigation. And what this investigation reveals is a picture of complacency and confusion that resulted in catastrophe.

As we heard in the public hearings back in May, this investigation also revealed some other issues – such as code sharing and pilot professionalism. But these issues are really larger than this accident itself. And the fact that the Board's final report may or may not address them does not diminish their importance.

Code sharing is a significant issue, and something we believe is worthy of examination – from a safety perspective – as it relates to the overall commercial passenger airline industry. And that is why staff is recommending that the Safety Board hold a public forum on code-sharing. This forum is tentatively scheduled for later this fall, so that the Safety Board can more comprehensively examine the safety implications of code-sharing arrangements. The Safety Board has already scheduled a public forum on pilot and controller excellence and high standards for later this spring. I believe that these forums are critical to continuing to keep the

public attention and pressure on the FAA to make positive improvements in the overall safety of our national air transportation system.

The report we are considering today concludes our accident investigation, but in many respects, it is just the beginning, of the Safety Board's work on these and other critical safety issues.

One final comment before we begin the presentations. During our discussion today, some disapproving, and even harsh, statements may be made about the actions of the Colgan Air flight crew – individuals who also lost their lives in this accident. I believe it is incumbent upon us to remember that, as we speak about the flight crew, we remember that we are speaking about individuals – a father, a wife, a parent, a husband, a child. The actions in the last minutes of their lives are not representative of the whole of their lives, and what each of them brought into the lives of those around them. This may be difficult for some to hear. But it is absolutely critical that we have an open and candid conversation so that we can make recommendations to improve aviation safety. It is not the Safety Board's role, nor our intention, to make any judgments beyond their performance as it relates to this investigation.

Now, for the report.

A few weeks ago, the NTSB staff submitted the following report for the Board's consideration:

Notation 8090A

Aircraft Accident Report
Loss of Control on Approach, Colgan Air, Inc Opearting as Continental Connection Flight 3407 Bombardier DHC-8-400, N200WQ Clarence Center, NY, February 12, 2009

The Board Members have had the intervening weeks to study these documents. While we might have met with staff individually to discuss the draft, today is the first opportunity for all of the Board Members to meet together to discuss the issues contained in the draft report.

During this meeting, the Board Members will hear staff presentations addressing the primary issues identified in the investigation, soliciting staff comments and explanations on many points. Once we have discussed the draft report, we will then consider the conclusions, probable cause determination, and specific safety recommendations proposed by staff.

Sometimes all or part of a draft conclusion, probable cause or recommendation is revised or rejected by the Members. This is because these are the Board's actual deliberations over the documents. That is the purpose of the Sunshine Act -- to provide the public with a window into the decision making process.

Approximately 30 minutes after this meeting, copies of the abstracts containing conclusions, probable cause, and recommendations approved by the Board can be obtained from the Board's Public Affairs Office.

BOB PERRY

LORIN MAURER – Passenger on Continental Flight 3407

" It's a beautiful day, and it is great to be alive", that is the motivating phrase that hung over the mirror in my daughters bedroom the four years she attended Rowan University to complete her undergraduate studies in Exercise Science and Health Fitness. When she went to the University of Florida to complete her Masters degree in Sports Management she again hung this phrase above the doorway exit from her bedroom. This slogan would appear three more times as a screen saver phrase streaming across the computer screen during her professional assignments with the NCAA, Mountain West Conference, and finally at Princeton University. The fact is that not every day is a beautiful day but to my daughter she believed it was the only way to begin each day if you want to be successful, motivated, and happy. And if your day does drift toward the many challenges we are all faced with in life……..then anchor yourself in this slogan and chances are you will be more focused on the good things in life versus those that can get you down.

Lorin celebrated her 30th birthday on December 28th, 2008. During the Christmas holiday of that year she shared with family that the relationship with her boyfriend Kevin Kuwik had become serious. Her exact words were, "I can see myself spending the rest of my life with Kevin". Coming from a girl who had put most of her young adult life on hold to pursue her dream of becoming a Division I Athletic Director, we knew she was in love. Although she lived in Princeton, NJ and Kevin in Indianapolis, IN they never went more than a few weeks without meeting someplace to spend time together.

February 12th, 2009 was to be such a rendezvous and was intended to be the start of a very romantic weekend in Buffalo, NY. Kevins' brother Keith was getting married on Valentines Day and Kevin would be the Best Man. Lorin was going to meet the entire Kuwik family for the first time. She was very excited about this trip and bought a special dress to wear for the occasion.

After boarding Continental flight 3407 at Newark airport that evening high winds resulted in causing a delay for safety. While the plane waited on the tarmac for the weather to improve, Lorin and Kevin text'd each other about the snow, ice, and cold weather in Buffalo that night. Lorin was not fond of cold weather and Kevin took the opportunity to playfully "rub it in" regarding the normal winter conditions for Buffalo, NY at this time of the year.

Finally after several hours of waiting for the winds to subside, Continental flight 3407 took off for Buffalo. Less than 60 minutes after take off 50 lives were lost and our family and Kevin will never see Lorin again. The world as we knew it was changed forever. My wife will not know the excitement of helping to select that perfect wedding dress. I will not get to walk her down the aisle to give her away in marriage. And worst of all Lorin lost the opportunity to live a full normal life and experience the joy of raising a family like we did. All of that was lost because of the terrible tragedy of Continental flight 3407.

It is unnatural for parents to bury their children. The days, weeks, and months since the accident have been mixed with emotions. Right now virtually every activity of our daily lives will cause us to think of Lorin and what might have been. Families of previous fatal airline accidents tell us that this will lessen but never go away. We are working very hard to anchor our thoughts and lives in the slogan that Lorin used for so many years to take a negative and turn it into a positive. And so I say to you with the love of my daughter hanging on every word, **"It's a beautiful day, and it is great to be alive"**.

Scott Maurer