



The Crash of Flight 201/8

by Linda Burdette, Feature Article Editor

November 8, 2011, will mark the 50th anniversary of one of the worst aircraft accidents in Virginia history. At the time, the crash of Imperial Airlines Flight 201/8 was the worst in Virginia history and the second deadliest accident in American history for a single civilian aircraft. Tragic though it was, this accident resulted in lasting changes in the governance of charter aircraft companies in the U.S. Typical for so many aircraft accidents, it was caused by a series of errors and the correction of any one of them could have avoided catastrophe.

A complete analysis of this accident must begin with the history of the “nonscheduled charter” airlines, or “nonskeds”, operating during this time. After World War II, some ex-military pilots bought surplus cargo planes at discount prices and began their own small airlines. Unfortunately, many of these airlines operated on a shoestring and for some, safety was far from the greatest concern. Nevertheless, the idea of former war heroes starting their own



L-049 Constellation

companies and contributing to the economy was very popular among politicians and federal agencies saw these cut-rate airlines as a good way to save taxpayer dollars. In 1958 Congress passed a bill which served to set aside a major portion of military personnel air transport to the nonscheduled airlines. Additionally, federal acquisition laws required that the Pentagon advertise for air charter services and then forced them to select the lowest bidder, which often turned out to be companies with poor safety records. This combination resulted in the military being almost dependent on the nonscheduled airlines and certainly did little to encourage the airlines to spend funds to improve their maintenance and safety records.

In February 1953, Regina Cargo Airlines began operating passenger services carrying servicemen on Civil Air Movements for the U.S. Government. Prior to the 1961 accident, it already had its share of issues. Its first fatal accident involving military personnel had occurred in 1933 when 21 persons were killed en route to McChord Air Force Base in a crash in Centralia, Washington. But in 1959, it jumped on the nonsked bandwagon in a big way when the Civil Aeronautics Board (CAB) issued a two-year operating certificate. It encountered issues almost immediately. In November of 1959 the FAA fined the company \$1,000 for operating a non-airworthy C-46 airplane with 30 Marines aboard. In June 1960, the company adopted the name Imperial Airlines, although there is no indication that the name change was any attempt to avoid association with the earlier accidents and issues. In November 1961, Imperial Airlines was headquartered in Miami and owned a fleet of three aircraft which made five or six unscheduled flights weekly carrying recruits to army stations. One of the three aircraft, N2737A, was a Lockheed L-049 Constellation purchased on 14 July 1961, and was destined to crash four months later.

The November 8, 1961, flight of N2737A was unusual from the beginning. First, the crew certainly did not meet the standard criteria. The L-049 normally carried a crew of three: a pilot in command (captain), a copilot (first officer) and a flight engineer. For Flight 201/8 both Captain Ronald Conway and First Officer James Greenlee were senior and had achieved captain's rank. However, the pilot designated as the first officer was senior and had more flying time than the pilot in command. Prior to the flight, when the two pilots realized that they were equally qualified to act as pilot in command, they agreed that the more senior one would function as co-pilot. Normally having two senior pilots would be an advantage during flight troubles, but in this case, according to the Civil Aeronautics Board, both pilots independently made conflicting decisions which had serious impacts on the emergency procedures.

Additionally, the flight crew included James Clark, a trainee "student flight engineer" who operated under the supervision of the official flight engineer, William Poythress. It was unclear in the ensuing investigation which one made the specific decisions about fuel management, but there was much speculation that perhaps the trainee was not adequately supervised to ensure that all decisions were correct. According to the CAB, this unusual mix of crewmembers contributed heavily to lack of communication and command and control of the aircraft. The final member of the crew was Stewardess Linda Johns of Miami.

Flight 201/8 departed Columbia, SC, at 15:24 EST, and made three successful stops before the accident. First they picked up 26 passengers in Newark, New Jersey; then 31 passengers in Wilkes Barre, Pennsylvania; and finally Baltimore, MD, where they picked up 17 passengers. After leaving Columbia on the first leg of the trip, the flight engineer noticed a drop in fuel pressure on the pressure gauge of the number 3 engine and opened the cross feed valves between the number 3 and 4 engines. This appeared to correct the fuel pressure problem and he continued to open this valve through each leg of the flight. The problem was not reported to the Captain and neither service nor maintenance were conducted at the ensuing stops.

They departed Baltimore at 19:12 hrs for a VFR flight to Columbia at an altitude of 4,500 feet. During that flight, the aircraft suddenly yawed to the right and about 30 miles northwest of Richmond, Flight Engineer Poythress reported fuel warning lights in engines 3 and 4. Immediately after, both right side engines Diagramshut down. When attempts to correct the problem failed, the pilot, now operating on only the two left engines with asymmetric thrust, decided to land at Byrd Field in Richmond. At this point, the similarity in the pilots' experience began to cause problems. There were indications of a lack of communication between the two pilots – both of whom appeared by this time to consider himself the pilot in command. With Captain Conway's acquiescence,

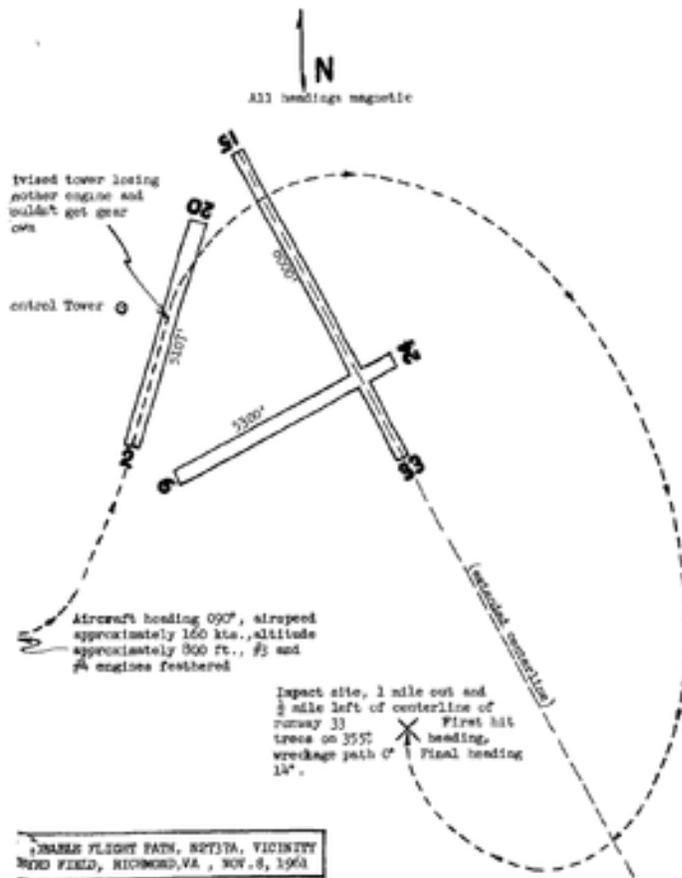


Diagram of Flight 201/8 approach to Byrd Airport

Lining up for landing, they realized that the hydraulic power to the landing gear was supplied by the two right side engines and the nose gear would not lock into place. They decided to do a go-around to gain time to get the landing gear deployed and locked. They apparently planned to land on Runway 33 on the second pass. However, on the turn for final approach, Flight Engineer Poythress reported losing power on engine 1 due to high engine temperature caused by the surge of power at low speed. Seconds before crash, the pilot radioed "I can't get my gear down and I'm losing another engine."

The pilots knew they were in trouble with only one engine. Conway saw the trees coming and Greenlee called "get on it with me, Ronnie" as the plane started to settle. Both grabbed the controls and put the airplane in a nose-high attitude to lessen the impact, feeling the jolt when they hit the trees. The airplane pancaked into a marsh two miles short of the runway, but Conway said the impact didn't seem particularly bad, although he was knocked forward, hitting the control wheel. According to witnesses, the airplane had regained about 700 feet of altitude when it crashed and there were reports of as many as three explosions immediately after the crash.

When Conway picked himself up after the crash, he and the rest of the crew realized the airplane was on fire. The cockpit crew opened the door to the cabin, but it was already full of smoke and they could see flames. Then they opened the crew door aft of the flight engineer's station and saw solid flames. The crew suddenly realized that the cabin was not a viable choice; exit through the crew door meant they would have to jump through the flames to the ground; and the cockpit was already filling with smoke. Conway was very slim, so he squeezed out a broken side window beside the pilot's seat. Greenlee and Poythress were unable to go through

Flight Engineer Poythress ordered Clark, the trainee, to go back to the passenger cabin and open the midship fuel crossfeed valve. Unknown to Conway, this order was rescinded by Greenlee who said "don't open that valve. You have good pressure on 1 and 2; leave it there." Conway testified later that he knew nothing of this until after the accident and assumed that the valve had been opened. In the meantime, Poythress unsuccessfully attempted to restart engine No. 3 and finally told Conway he had tried every procedure he knew and that he did not believe he could get 3 or 4 started. Conway made the decision that they should land the airplane.

Richmond tower told the crew to use runway 33, a northwest lane and 8,000 feet long, but Captain Conway later reported that since they were approaching from west they couldn't use it. So as they approached the airport, First Officer Greenlee, without warning to the Captain, turned to attempt a landing on runway 02.

the window and knew that they had to jump through the crew door and roll. Poythress took the leap, but Greenlee hesitated and it cost him his life. When Conway dropped to the ground, he turned and looked back at the plane. “The entire airplane was engulfed by flames except for a small part of the cockpit by that time.”

There were 79 persons on board – 74 passengers and 5 crew members. Only Conway and Poythress escaped the inferno. Everyone else was trapped inside and perished.

The CAB investigation revealed that none of the passengers had been advised of emergency procedures or emergency exits and went on to note the location of the bodies “indicated that many of the passengers had left their seats after impact and had attempted to evacuate the aircraft. The largest group of bodies was found near the main cabin entrance door, which either had been jammed by the ground impact or by trees and debris which were piled up against the fuselage.” Flight Engineer Trainee Clark and Stewardess Johns were found in the cabin with the passengers, but “[t]here was no evidence to indicate that attempts had been made to use any of the emergency over-the-wing window exits. The charred remains of what appeared to be the emergency escape slide retaining bar was found lying across the bottom of the main cabin door opening.”

Few remains could be fully examined for a cause of death, but two days later, the Medical Examiner said that at least 36 of the victims died of smoke inhalation, noting that fractures of the arms and legs could have come in the panic to flee the burning wreckage. Final medical reports revealed that virtually all deaths were due to

post-impact fire and carbon monoxide asphyxiation.



Photo of crash site

The public and private reaction to the horrific accident was immediate. The fact that so many of the young men were from small close-knit communities made the tragedy much more poignant. Twenty nine of the young men aboard that aircraft were from Pennsylvania’s Lehigh Valley, 14 of them from Bethlehem. A monument in Bethlehem, Pennsylvania, memorializes the victims at a small park off Route 378. The dedication reads: Dedicated to air crash victims – U.S. Army, Nov. 8, 1961.”

One of these men from Bethlehem was 22-year-old Thomas Motko. His sister related that, typical for the Viet Nam era, he was drafted into the Army and was not looking forward to his enlistment, but did joke with his mother that he was glad to be going to South Carolina for training “because he didn’t want to spend six weeks in New Jersey during the winter.” Like many of the victims, he was inducted that day, leaving from the Salvation Army in Bethlehem, and left at noon, calling his parents to tell them that he was on his way to South Carolina and would probably see them for Christmas. His father received an anonymous phone call from a New York newspaper at 4:30 the next morning telling him harshly that his son had died in the plane crash and asking for a reaction.

Two of the Bethlehem recruits were half-brothers, Joseph Champion and Stephen Kobli, who had enlisted with their boyhood pal, Leroy Kranch, Jr.

Frank Holman, Jr. of Baltimore was a lanky lad of 17. He had originally enlisted in the Air Force after high school graduation, but he wasn't called and he got tired of sitting around, so he got a release from the Air Force and joined the Army. His plan was to do three years of service and then go to the University of Maryland, hoping to play football there.

At least two of the recruits, Robert Bedics of Bethlehem, PA, and Millard Craft, Jr. of Baltimore were on their first airplane ride. Bedics was thrilled at the opportunity while Craft frankly hoped for any other mode of transportation, but assured his mother that he wasn't worried about his safety.

The facts of the incident, the public outcry from the victims' families, and an investigation by Time Magazine ensured that the CAB did a very thorough investigation of the accident. Unfortunately for Imperial Airlines, the CAB was extremely scathing in its assessment of the airline's management, maintenance, and flying procedures.

First, concerning the fuel issues that began the entire chain of events, the CAB concluded that the fuel pressure fluctuations were likely caused by a boost pump failure and as long as the engines were operating normally, the flight engineer should not have taken any action. However, the flight engineer's decision to open the cross-feed valves and leave them open with the boost pump on for most of the flight probably caused the number 4 tank to run dry, resulting in the failure of the right side engines due to fuel exhaustion.

In addition, the CAB detailed crew errors during the precautionary landing at Byrd Field. They stated: "From a study of all the information available to the Board it is concluded that this flight crew was not capable of performing the function or assuming the responsibility of the job they presumed to do. The Board further concludes that the management personnel of Imperial Airlines should have been aware of the manner in which company operations were being accomplished. It is believed that the substandard maintenance practices of Imperial's employees were condoned by management. The manner in which maintenance and personnel records were kept by the company confirms this conclusion." The CAB's Probable Cause statement is particularly damning: "The Board determines the probable cause of this accident was the lack of command coordination and decision, lack of judgment, and lack of knowledge of the equipment resulting in loss of power in three engines creating an emergency situation which the crew could not handle."

Time Magazine also printed some particularly critical articles focused on the nonscheduled airlines in general. These articles included statistics showing that the nonsked were "more than 30 times as dangerous" in the numbers of fatalities per passenger mile than the scheduled airlines. In 1961, the nonscheduled airlines flew 1.5 billion passenger miles compared to the scheduled airlines 39.8 billion. In 1961, there were nine fatalities per 100 million passenger miles on the nonskeds versus 0.29 fatalities on the scheduled airlines.

Time also reported that after the Richmond crash, the CAB and FAA began to investigate the nonscheduled airlines as a whole and were appalled at what they found. They reported mechanics writing maintenance reports on non-existent repairs and evaluations; pilots flying more than the legal eight hours at a stretch; and extremely poor flight training standards.

As a result of the accident and the public outcry over Time's revelations, Congress began to look into the safety records of these supplemental carriers. U.S. Representative Francis E. "Tad" Walter was the Congressman from the Easton, Pennsylvania, area. He received news of the crash as he was traveling from Washington, D.C. to his district. He turned the car around and headed back to Washington. His aide, Jack Yohe, reported that he immediately met with Secretary of Defense Robert McNamara and demanded an investigation of all the nonscheduled airlines and military charter operations.

By 1962, the CAB had tightened up its certification requirements. However oddly enough, the CAB's increased scrutiny did not extend to safety and maintenance violations. Their approach was that the companies' financial hardships had led them to exercise slipshod training and maintenance practices, so if the government ensured that the airlines were financially sound, the safety and training issues would be moot. They relied solely on the FAA to address the maintenance and safety concerns. Regardless of the background, that year, Congress mandated that all supplemental carriers meet the higher requirements, including carrying liability insurance and maintaining a healthy financial status. Many supplemental carriers went out of business in the aftermath, including Imperial Airlines, whose license to operate was revoked by the CAB six weeks after the accident.

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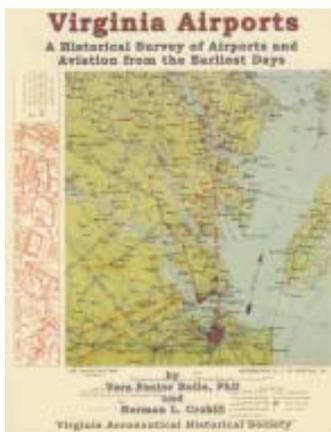
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