NATIONAL TRANSPORTATION SAFETY BOARD
Office of Aviation Safety
Washington, D.C. 20594

January 4, 1995

ADDENDUM

AIR TRAFFIC CONTROL GROUP CHAIRMAN'S FACTUAL REPORT

A. ACCIDENT

Aircraft:	USAir flight 1016, McDonnell Douglas DC-9-31, N954VJ
Location:	Charlotte/Douglas International Airport, Charlotte, North Carolina
Date:	July 2, 1994
Time:	1842:25 Eastern Daylight Time (EST) (2242:25 UTC)
NTSB No:	DCA-94-MA-065

B. SUMMARY

On July 2, 1994, USAir Flight 1016, a DC-9-31 aircraft, collided with terrain while executing a missed approach to runway 18R at the Charlotte/Douglas International Airport (CLT), Charlotte, North Carolina. There were 52 passengers and 5 crew members of which 37 sustained fatal injuries. All of the flight crew members survived. The airplane was totally destroyed.

C. ADDITIONAL INFORMATION

On October 12, 1994, the ATC Group reconvened at the Marriott Executive Park Hotel, Charlotte, North Carolina to conduct depositions. Various personnel at the Charlotte facility and FAA HQ were deposed regarding the Charlotte ATCT 7220.4 Standard Operating Procedures (SOP), Chapter 4, "Controller-In-Charge Cab Coordinator," Section 1, "Position Duties and Responsibilities," paragraph 4-10f, Controller-In-Charge Responsibilities. During the investigation, the NTSB discovered three versions of paragraph 4-10f. The depositions were to 1) clarify which version was current at the time of the accident and 2) determine how the three versions got into the system.

Six people from the Charlotte facility and one person from FAA HQ were deposed. Persons interviewed from the Charlotte facility were: Bridgette Lewkowicz, Charlotte Plans and Procedures Specialist; Brian Lentini, Assistant Air Traffic Manager; James Koon, Plans and Procedures Specialist; Cecil Hall, Assistant Manager for Traffic Management; Philip Loftin, Air Traffic Manager; James Dale Wright, President of NATCA Local Charlotte Facility. From FAA Headquarters was Wayne Pierce, Air Traffic Control Specialist from the Quality Assurance Division.

Everyone deposed, except Mr. Wright who could not recall, stated that the version current at the time of the accident was "Determine the prevailing visibility when required and ensure that visibility is relayed to the National Weather Service." The changes came about after the field phase of the NTSB investigation when the facility management decided that improvements could be made to strengthen the paragraph. The problems arose when the changes were initiated by management without adequately briefing the facility personnel and without making the necessary changes to the document. For example, the vertical line next to the affected paragraph and the effective date were not properly annotated. Although the document was routed through three individuals, no one noticed the omissions because of the rush to get the document in place before the arrival of the FAA evaluation team that was due in September.

Additionally, the Safety Board learned that there are no written procedures regarding the dissemination of changes to documents. At the time of the accident, the normal procedure was that the PPS changed the document, the Assistant Manager for Plans and Procedures reviewed and approved the change, the Air Traffic Manager reviewed and approved the change, then approximately 10 days before the effective date, the document was disseminated to the controllers. After the accident, changes were implemented to ensure that the National Air Traffic Controllers Association (NATCA) initialed documents before releasing them to the controllers. However, there are no local or national procedures which dictate how a change to any document should be accomplished.

[redacted]
Sandra L. Simpson
ATC Group Chairman
RSW 1/4/95