Docket No. **SA-509**

Exhibit No. **3L**

NATIONAL TRANSPORTATION SAFETY BOARD

WASHINGTON, D.C.

RESPONSE LETTER FROM THE MANAGER, CHARLOTTE AIR TRAFFIC CONTROL TOWER

U.S. Department of Transportation
Federal Aviation Administration

Memorandum

Subject: INFORMATION: CLT ATCT 7220.4, CLT ATCT

Date: October 3, 1994

From: Manager, Charlotte Air Traffic Control Tower
6487

Reply to Attn. of: Loftin [redacted]

To: Manager, Investigations Branch, ATH-210
ATTN: Wayne Pierce

Charlotte 7220.4, CLT ATCT STANDARD OPERATING PROCEDURES, replaced 7220.3, and was effective 11/11/93. Briefings for 7220.4 were accomplished between 11/4/93 and 11/11/93.

On July 2, 1994, the date of USAir 1016 accident, CLT 7220.4, Chapter 4, Section 1, paragraph 4-10.f read as follows: "Determine the prevailing visibility when required, and ensure visibility is relayed to the National Weather Service."

On July 3, 1994 several complete copies of CLT 7220.4 were provided to Wayne Pierce as part of the initial accident information package. After the NTSB completed their on-site investigation, CLT facility management, regional ASO-540 representatives and Mr. Pierce discussed the issuance of visibility and our facility requirements. Upon reviewing the 7220.4 (specifically Chapter 4, Section 1, paragraph 4-10) we determined that we should strengthen this area by including the following (... and inform each operational position in the tower of the visibility. (NOTE: A "BLANKET" BROADCAST IS NOT ACCEPTABLE.)" The Procedures office was directed to I&I this change, which was done, and to coordinate with Training and Quality Assurance to have this change included in the scheduled August 8 SOP briefing package for the August 18, 1994 change to the 7220.4.

The Procedures Specialist determined that this could be done easily by pulling the page (page 41) of 7220.4 up on the computer and adding the above-noted phrase to paragraph 4-10.f. Two administrative errors occurred in this process. 1) The change date of 8/18/94 was not recorded on the page. 2) We "dropped the ball" somewhere between Procedures and Training and did not brief this change.

On the morning of September 27, 1994, Mr. Wayne Pierce called me to question this page in the 7220.4 and how he had one version of paragraph f and NATCA had given the NTSB another version. Upon investigating our records and questioning our personnel, I discovered that the "change and NOTE" was in our 7220.4, but could find no record of it

having been briefed, either on July 21, 1994 in a post-accident briefing or on the August 8, 1994, 7220.4 Change 5 briefing. I informed Mr. Pierce of this and then instructed the Procedures staff to remove all pages to the 7220.4 binders with their obvious error and replace this page with the original wording to paragraph 4-10.f. I then instructed the Assistant Manager for Training to have a proper and complete briefing package prepared and briefed. This briefing will commence on October 3, 1994 and be implemented in the October 13,1994 change to 7220.4.

After I had discovered the discrepancies on September 27th, and made the changes back to the original wording, the NATCA rep received calls from other NATCA people about this developing issue. He returned to the facility after we both left at the end of the day and confirmed that the original page 41 of 7220.4 was indeed in the binder and found discarded and erroneous pages in my trash can...where I placed them after having them removed. He then faxed copies of these discarded pages to the NATCA folks he had been communicating with. The next day, I was talking with our NATCA representative who told me that he had given a copy of the pages in question to NATCA folks at the Regional and/or Washington level. The NATCA rep stated that he "thought this had always been a requirement to inform each position and that he had been trained this way and did it this way."

We obviously made some administrative errors, which were corrected. The decision to strengthen a procedure we found in the post-accident days was consistent with our policy to "do things better every chance we get." It does not necessarily mean the procedure was wrong...we simply thought it could be clarified and made even better. We do this all the time regardless of the reason for review!

There was no attempt at any time by anyone at Charlotte Tower to "cover-up" or alter the facts in this or any other aspect of this accident and the subsequent investigation by this facility, the FAA, the NTSB or any other interested party.

It is also my firm belief that the Charlotte NATCA representative provided the information, requested by his organization, in good faith and with no intent to discredit or cast doubt on his facility in any way.

In addition, it should be noted that the days and weeks following this accident, Charlotte Tower personnel were stretched to the limit with post-accident activity, preparation for a full-facility evaluation by ATH, the NTSB public hearings and various other activities and workgroups outside the facility. That some administrative errors occurred during this period was unfortunate, but not incomprehensible!

[redacted]
Philip L. Loftin