Factual Report – Attachment 1

Interview Summaries

AIR TRAFFIC CONTROL

ERA17FA190

Interviewee: David Dreyer, South Arrival (SA) Controller
Representative: Grant Mulkey, Attorney for NATCA

Date / Time: May 30, 2017 / 1500 EDT
Location: Philadelphia Air Traffic Control Tower (PHL ATCT)
Present: Heidi Kemner – NTSB, Mike Hodges – NTSB, Ross Knoll – FAA, Eric Stormfels – NATCA, Patrick Ream - NATCA
Investigator: Brian Soper

During the interview Mr. Dreyer stated the following:

His air traffic control experience began in September of 2001 at the FAA Academy in Oklahoma City, Oklahoma. After successful completion of initial air traffic control (ATC) training, he was assigned to Allentown (ABE) ATCT where he remained until accepting a position at PHL ATCT in September of 2013.

Mr. Dreyer worked a rotating shift schedule, with regular days off on Sunday and Monday. His work schedule for the week leading up to, and the day of the accident was:

Friday	0700 - 1500	
Saturday	0600 - 1400	
Sunday	Off	
Monday	Off	
Tuesday	Leave	
Wednesday	1430 - 2230	
Thursday	0730 - 1530	(Day of accident)

He was the SA controller, combined with Dupont and South High sectors at the time of the accident; this was a routine configuration at PHL ATCT. He was certified on SA in December of 2015 and was current and proficient on the position in accordance with facility standards. He had no suspensions or documented operational incidents while at PHL ATCT. He was a member of the OJTI refresher cadre at PHL ATCT and had not been on any recent details. He recalled nothing remarkable about the 72 hours leading up to the time of the accident, and reported routine daily activities, sleep, and meals.

His operating initials[1] were DR and his supervisor of record was Tim Hughes. He possessed a current second class medical certificate and his last ATC physical had been conducted in April of 2017. He was required to wear corrective lenses while performing ATC duties, and stated that he was wearing them at the time of the accident. He had no other waivers or restrictions to his medical certificate. He held no other aeronautical ratings or certifications.

[1] Operating Initials – Every air traffic controller is assigned "operating initials" that they use to identify themselves in radio communications and coordination with other controllers and control facilities, as well as on administrative documents such as facility logs, position logs, etc. These initials are unique to each person within an air traffic control facility and are not necessarily their actual initials.

On the day of the accident, he was working his normally scheduled shift and recalled there had been significant weather moving away from the area in the morning but was not sure if it was IMC[2] or VMC[3] at the time of the accident. He had reviewed the audio and video replays of the event with staff prior to the day of the interview. He stated that no training was being conducted on SA at or leading up to the time of the accident. On a scale of 1 to 5 (5 being the heaviest) he classified the traffic volume as 3 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as 3 at the time of the accident. He said that a relief briefing was conducted when he assumed the SA position, and that it was recorded, and a checklist was utilized. He did not perform toxicology testing as a result of this accident. He did file an ATSAP[4] report following this accident but had only received confirmation of receipt from the Event Review Committee (ERC).

He was not sure how long he had been on position prior to the accident but recalled the pilot of N62UP checking in from Atlantic City (ACY) and he provided the pilot the PHL and New Castle Airport (ILG) altimeter settings and advised the pilot of the instrument approach procedure in use at ILG. He advised the pilot that ATIS[5] information "Tango" was current at ILG, and the pilot responded he would advise when he had "Tango". He recalled instructing the pilot of N62UP to fly a heading of 280, then 270, and finally another 10 degrees left. The additional 10-degree turn was due to the wind being out of the south and were pushing N62UP further north than he had anticipated. He continued providing services to the pilot of N62UP until transferring control responsibility to the south departure (SD) controller. He did not recall anything being out of the ordinary during the time he provided services to N62UP.

He recalled the pilot of N62UP had asked for his IFR[6] clearance back to ACY, and that he could not locate a pending flight plan in the system. He did pass the information along to the SD controller when he handed him off.

When asked, he said that he could not recall any problems with the NIDS[7] weather information timing out but said sometimes the wind information on the NIDS would "X out", and that the aural alarm was annoying when that happened.

Interview concluded at 1550 EDT.

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[2] IMC – Instrument Meteorological Conditions − Meteorological conditions expressed in terms of visibility, distance from cloud, and ceiling less than the minima specified for visual meteorological conditions.
[3] VMC – Visual Meteorological Conditions – Meteorological conditions expressed in terms of visibility, distance from cloud, and ceiling equal to or better than specified minima.
[4] ATSAP – Air Traffic Safety Action Program – A Voluntary reporting program that allows air traffic controllers and other employees to report safety and operational concerns.
[5] ATIS – Automatic Terminal Information Service – A continuous broadcast of current, routine information to arriving and departing aircraft by means of continuous and repetitive broadcasts throughout the day or specified portion of the day.
[6] IFR – Instrument Flight Rules – Rules governing the procedures for conducting instrument flight. Also a term used by pilots and controllers to indicate type of flight plan.
[7] NIDS – National Airspace System (NAS) Information Display System – A real-time data collection and display system that provides air traffic controllers access to traffic, weather, and surveillance data in one touch-screen workstation.

Interviewee: Jimmie White, South Departure (SD) Controller
Representative: Grant Mulkey, Attorney for NATCA

Date / Time: May 31, 2017 / 0935 EDT
Location: PHL ATCT
Present: Heidi Kemner – NTSB, Ross Knoll – FAA, Eric Stormfels – NATCA, Patrick Ream – NATCA
Investigator: Brian Soper

During the interview Mr. White stated the following:

His air traffic control experience began in September of 1989 in the United States Air Force (USAF) where he served as an air traffic controller until his honorable discharge in 1999. In September of 1999, he was hired by the FAA at the Cleveland Air Route Traffic Control Center (ZOB ARTCC) and continued working there until he was transferred to PHL ATCT in September 2003.

He worked a rotating shift schedule with regular days off on Sunday and Monday. His work schedule for the week leading up to, and day of the accident was:

Friday	Off	
Saturday	Off	
Sunday	1500 - 2300	
Monday	1500 - 2300	
Tuesday	1300 - 2100	
Wednesday	0700 - 1500	
Thursday	0600 - 1400	(Day of accident)

He was the south departure (SD) controller, combined with Dupont and South High sectors at the time of the accident. This configuration was routine at PHL ATCT. He was not certain of the date but stated that he had been certified on SD for years. He was current and proficient on the position at the time of the accident in accordance with facility standards. He had been involved in a loss of separation event years earlier but had no other history of operational incidents or suspensions while at PHL ATCT. He was part of the TAMR[8] working group which included travel to the FAA Technical Center in Atlantic City, New Jersey for three weeks within the last couple of months. He recalled nothing remarkable about the 72 hours leading up to the time of the accident, with routine daily activities, sleep, and meals.

His operating initials were JQ and his supervisor of record was Jeff Szakacs. He possessed a current second-class medical certificate and his last ATC physical had been conducted in February of 2017. He had no waivers or restrictions to his medical certificate. He held no other aeronautical ratings or certificates.

[8] TAMR – Terminal Automation Modernization and Replacement – The FAA program upgrading air traffic control systems at terminal radar approach control (TRACON) facilities across the NAS with the Standard Terminal Automation Replacement System (STARS).

On the day of the accident, he worked his normally scheduled shift and recalled that ILG was reporting IFR; however, he did not recall seeing precipitation on his radar display. He had reviewed the audio and video replay of the event with staff prior to the day of this interview. He stated that no training was being conducted on SD at or leading up to the time of the accident. On a scale of 1 to 5 (5 being the heaviest) he classified the traffic volume as 3 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as 3 at the time of the accident. He said that a PRB was conducted when he assumed the position and that it was recorded, and a checklist was utilized. He did not perform toxicology testing as a result of this accident. He did file an ATSAP report following the accident and had received no feedback.

He had accepted a handoff on N62UP from the SA controller. There was discussion with somebody he could not readily recall at the time of the handoff about the pilot wanting to pick up an additional IFR flight plan back to ACY. He checked with the flight data (FD) controller but was informed that there was no outbound flight plan information in the system for N62UP returning to ACY. He recalled radar identifying a departure from ILG and had begun to work the departing airplane around a couple of overflights, along with a departure from PHL and was coordinating more efficient routing. He then vectored N62UP to intercept the localizer at ILG, issued a descent from 3,000 feet above mean sea level (msl) to 2,000 feet msl. As N62UP neared the final approach course, he instructed the pilot to turn an additional ten degrees to the left. He stated this was to provide a better intercept angle to N62UP. He then cleared N62UP for the ILS[9] runway (RWY) 1 approach to ILG. About the time that N62UP was crossing the final approach fix, he instructed the pilot to contact ILG tower.

A short time later, he received a call from ILG ATCT advising him that N62UP was going to go-around and execute the published missed approach. When N62UP had not checked in, and he did not see him on radar, he called ILG ATCT to ask for the status and they said they were also trying to get ahold of the pilot. At that time, he thought that the aircraft may have landed, but then ILG ATCT called back and sated they could see black smoke to the south and Mr. White said he began to worry.

He felt the workload and traffic on the day of the accident was routine. He did not recall looking back at N62UP after he had transferred communications to ILG ATCT. He stated the current ATIS code for ILG was already marked on the flight progress strip, which was the normal procedure at PHL ATCT, and therefore he did not issue the information to the pilot. He was required to be soliciting PIREPs[10] around the time of the accident because the weather was IMC, and knew he had received at least one PIREP, but could not recall if it was before or after the accident. He stated that he did not write that PIREP down, however had passed it verbally to either the FD controller or the front-line manager (FLM).

When asked if he recalled any distractions around the time of the accident, he did recall some issues with the NIDS weather at satellite airports such as Trenton-Mercer Airport (TTN),

[9] ILS – Instrument Landing System – A precision instrument approach system that normally consists of a Localizer, Glideslope, Outer/Middle Markers, and approach lights utilized by a properly equipped pilot to conduct an ILS approach.
[10] PIREP – Pilot Weather Report – A report made by a pilot of meteorological phenomena encountered by an aircraft in flight.

Northeast Philadelphia Airport (PNE), and ILG, but said he would not classify them as distractions. He said that the failure of the weather link may occur once every week or so but would not classify it as often.

He did not treat IFR helicopters any different from IFR fixed wing aircraft and had no expectation of additional requirements by helicopter flights either. He stated the coordination that he had conducted involving the departure from ILG around the time of the accident was routine. He said that he knew several ways to solve the traffic situation and perform the coordination with that type of departure. When asked if the published missed approach for the ILS RWY 1 approach at ILG included a turn to the southwest was due to traffic using RWY 9R at PHL, he did not know.

Mr. White stated that if the SD, Dupont, and south high positions had not been combined at the time, he would not have done anything differently. He further stated his focus was on all the traffic.

He said there was no return flight plan in the system for N62UP. He knew the pilot would be looking for it eventually, and he had anticipated having to manually enter a flight plan for him. He had no idea how many approaches the pilot of N62UP had planned on performing at ILG, whether it would be a "one and done" or if he would be doing multiple approaches. Though he did not realize it at the time he was providing services to N62UP, he later learned that it was a Penn Star helicopter. He said they often provides services to Penn Star helicopters at PHL ATCT, but he had never worked one that was IFR.

He did not recall when the last standard weather refresher training on PIREPs and seasonal weather had been conducted, but stated they were normally conducted via computer-based instruction (CBI).

He understood the approach gate and associated procedures for vectoring IFR aircraft to final approach. He also understood the PHL ATCT video map markings and stated that the end of the line that extended from the outer marker on their map was the "target" point for intercept when vectoring aircraft to final in IFR conditions.

Interview concluded at 1030 EDT.

Interviewee: Scott Lovick, Operations Manager (OM)
Representative: Matthew Smith, Attorney for the FAA

Date / Time: May 31, 2017 / 1400 EDT
Location: PHL ATCT
Present: Heidi Kemner – NTSB, Ross Knoll – FAA, Eric Stormfels – NATCA
Investigator: Brian Soper

During the interview Mr. Lovick stated the following:

His air traffic control experience began in April of 1994 when he completed the Collegiate Training Initiative (CTI) program and was employed by the FAA at Los Angeles ARTCC (ZLA

ARTCC). In August of 2002, he transferred to PHL ATCT where he worked until August of 2015 when he accepted a position with Mission Support (AJI-14) at FAA headquarters. In January of 2016 he returned to PHL ATCT as an OM.

He worked a rotating shift schedule with regular days off on Saturday and Sunday. His work schedule for the week leading up to, and day of the accident was:

Friday	0700 - 1500	
Saturday	Off	
Sunday	Off	
Monday	1300 - 2100	
Tuesday	1100 - 1900	
Wednesday	1030 - 1830	
Thursday	1030 - 1830	(Day of accident)

He was OM at the time of the accident. He had been certified on the OM position since returning to PHL ATCT in January of 2016. He was an adjunct professor at Delaware State University and had been on a recent detail as the acting air traffic manager (ATM) at Syracuse (SYR) ATCT from August of 2016 to January of 2017. He recalled nothing remarkable about the 72 hours leading up to the time of the accident, with routine daily activities, sleep, and meals.

His operating initials were UD and his supervisor of record was Dana Rose-Kelly. He possessed a Certified Flight Instructor (CFI), CFI – Instrument (CFII), Multi-Engine – Instrument, and Commercial Pilot ratings, however was not current.

On the day of the accident, he was working his normally scheduled shift and recalled that the weather was predominantly IFR but did not recall if there was any precipitation displayed on the radar displays around the time of the accident. He had reviewed audio and video replays of the event with staff prior to the day of this interview. On a scale of 1 to 5 (5 being the heaviest) he classified the traffic volume as 3.5 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as a 3.5 at the time of the accident. He said that a PRB was conducted when he assumed the position, a checklist was utilized, and it was recorded.

He recalled that around the time of the accident, they had been handling one aircraft with a medical emergency, and one with an emergency due to "flap issues", as well as initiating a Temporary Flight Restriction (TFR) for a propane leak that had been reported by the Gloucester County sheriff's office in New Jersey. He had been on position for about 30-40 minutes prior accident and remained on position for about 1 hour after. He first became aware there was a potential problem with N62UP when he received a call from ILG ATCT reporting a possible accident. At the same time, John Bracket had also approached him and told him to go talk to "Jimmie" who was the SD controller at the time. He then asked the FLM to have Jimmie relieved from SD so that he could speak with him. He then returned to the OM desk and called the ATM, regional operations center (ROC), and called ILG ATCT back as well, and that was about the time that the front office arrived to assist. From that point forward, he was mainly involved with notifications, coordination, and completion of the mandatory occurrence report (MOR).

He stated that he knew how to pull up a FALCON[11] replay, as well as how to mark a last known position with the STARS[12] to provide the information to those involved in the search and rescue (SAR) operations of a downed or missing aircraft.

When asked if he thought splitting the positions (SD, south high, and Dupont) instead of leaving them combined may have allowed the controller to easier recognize N62UP failing to descend on final, he did not know.

He recalled some training on PIREP and weather dissemination being contained in the last recurrent training that took place in May or April of 2017 but did not recall the contents.

Interview concluded at 1440 EDT.

Interviewee: Jeffrey Szakacs, Front Line Manager (FLM)
Representative: Matthew Smith, Attorney for the FAA

Date / Time: May 31, 2017 / 1130 EDT
Location: PHL ATCT
Present: Heidi Kemner – NTSB, Ross Knoll – FAA, Eric Stormfels – NATCA
Investigator: Brian Soper

During the interview Mr. Szakacs stated the following:

His air traffic control experience began in March of 1997 when he completed the CTI program and was employed by the FAA at New York ARTCC (ZNY). In May of 1998 he accepted a position at ABE ATCT and remained until April of 2002 when he transferred to PHL ATCT.

He worked a rotating shift schedule with regular days off on Friday and Saturday. His work schedule for the week leading up to, and day of the accident was:

Friday	Off	
Saturday	Off	
Sunday	1500 - 2300	
Monday	1500 - 2300	
Tuesday	1000 - 1800	
Wednesday	0600 - 1400	
Thursday	0500 - 1300	(Day of accident)

He was the FLM on duty at the time of the accident. He was certified as FLM in January of 2010 and was current and proficient in accordance with facility standards. He had no

[11] FALCON – Software providing for the instant/rapid replay of ATC operational incidents in a format much like the one displayed to the ATC specialist. It is used in terminal radar facilities to review training management issues, investigate accidents and operational incidents, develop specialty training programs, and present facility-wide briefings on operational incidents.
[12] STARS – Standard Terminal Automation Replacement System – A system that receives radar data and flight plan information and presents the information to air traffic controllers on high resolution, 20" x 20" color displays allowing the controller to monitor, control, accept hand-off of air traffic, and assist with weather avoidance.

documented operational incidents or suspensions while at PHL ATCT. He was the management Occupational Safety and Health Administration (OSHA) representative at PHL ATCT and had not been on any recent details. He recalled nothing remarkable about the 72 hours leading up to the time of the accident, with routine daily activities, sleep, and meals.

His operating initials were JP and his supervisor of record was Danny Mullin. He possessed a current second-class medical certificate and his last ATC physical had been conducted in October of 2016. He had no waivers or restrictions to his medical certificate. He was a rated private pilot, however was not current.

On the day of the accident, he was working his normally scheduled shift and did not recall any unusual distractions around the time of the accident. He recalled the weather being IFR, with ceilings below 1,000 feet above ground level (agl) and did not recall any precipitation being displayed on the radar displays. He had not reviewed replays of the event. He stated there was no training being conducted on FLM at or leading up to the time of the accident. On a scale of 1 to 5 (5 being the heaviest) he classified the traffic volume as 3 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as 3 at the time of the accident. He said that no relief briefing was conducted when he assumed the position because he was opening the position for the day. He did not file an ATSAP report as a result of this accident. He did not perform toxicology testing following this accident.

He did not recall how long he had been on position prior to the time of the accident, but said he remained on for only about 5-10 minutes after the time of the accident. He was first made aware there was a potential problem when the OM approached him and asked him to get Jimmie relieved from SD. Jimmie was not next in the break list, but he knew something was going on, so he provided a relief for Jimmie. He then followed the OM back to the OM desk to find out what was going on, and the OM informed him that there had been a crash at ILG. After that, everything was handled by the OM and he had no further involvement with the accident.

When asked about PIREP dissemination and how it was done at PHL ATCT, he said that normally when controllers received a PIREP they would hand it to him on a PIREP form or maybe on the back of a flight progress strip, and he would then enter it into AISR[13]. He said that when he received several PIREPs in a short amount of time, he may not get them all entered. He did not feel this was a frequent occurrence, but it sometimes happened. He had entered null reports in the past, and though sometimes had put in "multi-type" PIREPs (multiple aircraft, multiple flight levels, etc.) he did not feel that it was a routine practice.

When asked if he thought splitting the positions (SD, south high, and Dupont) instead of leaving them combined may have allowed a controller to easier recognize N62UP failing to descend on final, he said he was not sure and that each controller was different.

[13] AISR – Aeronautical Information System Replacement - a web-enabled, automation means for the collection and distribution of Service B messages, weather information, flight plan data, Notice to Airmen (NOTAM) messages, Pilot Report (PIREP) message, and other operational information to all FAA Air Traffic facilities.

The last training that included PIREP and weather dissemination that he could recall was probably in the last recurrent training. He recalled something being discussed about the Air Traffic Organization (ATO) "Top 5" and weather dissemination.

He estimated that he had written one performance record of counseling (PRC) in the last month. He stated that they tried to handle counselings verbally whenever possible rather than writing all of them up on a PRC.

He said that there was no formalized weather briefing process or procedure for controllers or supervisors at PHL ATCT, and that most often a controller received their weather information through the position relief briefing. As FLM he would normally take a look at the ceiling and forecast for the next 12 hours, and of course take a look at the ASOS[14], that was basically it. He could not recall ever reaching out to the Center Weather Service Unit (CWSU) for weather support or information.

Interview concluded at 1210 EDT.

Interviewee: James DuBois, Front Line Manager (FLM)
Representative: Matthew Smith, Attorney for the FAA

Date / Time: June 1, 2017 / 1030 EDT
Location: ILG ATCT
Present: Heidi Kemner – NTSB, Ross Knoll – FAA, Eric Stormfels – NATCA
Investigator: Brian Soper

During the interview Mr. DuBois stated the following:

His air traffic control experience began in 1986 in the USAF where he served as an air traffic controller at Castle Air Force Base (AFB), in Atwater, California until his honorable discharge in 1994. In the summer of 1994 he worked with Midwest ATC at Martha's Vineyard (AVY) Federal Contract Tower (FCT). He then worked a short time as a Department of Defense air traffic controller at Pease AFB Radar Approach Control (PSM RAPCON). He was hired by the FAA in September of 1997 and was assigned to ZNY ARTCC until 1998 when he transferred to Caldwell (CDW) ATCT. From 2000 to 2001 he worked at Providence (PVD) ATCT, then at Portland (PWM) ATCT from 2001 to 2004. In January of 2004 he was transferred to ILG ATCT.

He worked a rotating shift schedule with regular days off on Friday and Saturday. His work schedule for the week leading up to, and day of the accident was:

Friday	Off
Saturday	Off
Sunday	1000 - 1800

[14] ASOS – Automated Surface Observing System - Automated sensor suites that are designed to serve meteorological and aviation observing needs. There are currently more than 900 ASOS sites in the United States. These systems generally report at hourly intervals, but also report special observations if weather conditions change rapidly and cross aviation operation thresholds.

Monday	0615 - 1415	
Tuesday	0715 - 1515	
Wednesday	0615 - 1415	
Thursday	0615 - 1415	(Day of accident)

He was the local controller (LC) when the accident aircraft established radio contact with ILG ATCT but had been called away from the position by the relieving controller to assist with a computer sign-on problem. The relieving controller answered the pilot of N62UP upon initial contact. Mr. DuBois then immediately conducted a position relief briefing and attended to the computer problem.

He was certified in January of 2004 and was current and proficient on the position he was working at the time of the accident in accordance with facility standards. He had no suspensions or documented operational incidents while at ILG ATCT. He held no collateral duties and had not been on any recent details. He recalled nothing remarkable about the 72 hours leading up to the time of the accident, with routine daily activities, sleep, and meals.

On the day of the accident, he classified the weather as lower ceilings of about 800 feet agl. He had received a PIREP confirming the cloud heights earlier in the morning. He stated it may have rained earlier in the morning, but it was mist which was the obstruction to vision they were encountering at the airport. He had reviewed the audio and video replay of the event with staff prior to the day of this interview. He stated that no training was being conducted in the tower at or leading up to the time of the accident. On a scale of 1 to 5 (5 being the heaviest) he classified the traffic volume as 2 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as 2 at the time of the accident. He said that a relief briefing was conducted when he assumed the position, and that it was recorded but a checklist was not utilized. He did not perform toxicology testing as a result of this accident and did not file an ATSAP report.

His operating initials were JD and his supervisor of record was Bruce Keller. He possessed a current second-class medical certificate and his last ATC physical had been conducted in November of 2016. He had no waivers or restrictions to his medical certificate. He held no other aeronautical ratings or certificates.

On the day of the accident, he was working his normally scheduled shift and recalled the tower staffing as Ms. Anira Snow-Richardson working the combined positions of FD, clearance delivery (CD), ground control (GC), and controller-in-charge (CIC) from the GC position, and himself working LC. His staffing plan was for the next person in the rotation to relieve him so that he could finish required administrative duties. Mr. David Jordan came to the tower and relieved Ms. Snow-Richardson. Ms. Snow-Richardson was moving to the LC position, and was having difficulty with the sign-on computer entries. He noticed her having difficulty and attempted to correct the issue but realized that the problem was going to take more in-depth troubleshooting. Ms. Snow-Richardson was standing by the LC position when the pilot of N62UP first called up and she picked up the headset and cleared N62UP to land. Mr. DuBois then returned to the LC position and conducted a PRB with the hand set. He looked up at the tower radar display and saw N62UP displayed just inside the outer marker. He then returned to the sign-on computer to continue troubleshooting.

He was still in the tower cab when he heard Ms. Snow-Richardson say, "where did he go." He turned around and looked at the radar display again and did not see N62UP. He then scanned the runway and did not see N62UP on the runway either. He listened to Ms. Snow-Richardson coordinate with PHL ATCT, and at the same time, another FLM (Mr. David Jordan) who had arrived in the tower to relieve Mr. DuBois, looked out the window and stated, "oh Jimmy." Mr. DuBois then looked out the window and saw black smoke and immediately instructed Mr. Jordan to ring crash phone while he began making required notifications.

Mr. DuBois stated that the problems with the sign-on computer were a distraction. Ultimately, it was determined that the computer problem was caused by an approved leave request that had not been cancelled as requested by Ms. Snow-Richardson. He only remembered looking and seeing the helicopter on the radar display the one time, when he was just inside the outer marker. He stated that the LC had caught his attention when she asked where he went. He recalled a transmission about a missed approach at some point, but it seemed routine and therefore, he did not really key in on the conversation.

He said that the tower was notified of arrivals to ILG via the "scratch pad" function of STARS, which allowed the approach control to enter in pertinent arrival information into the electronic data block, which would be displayed on the tower radar display. They also received an arrival flight progress strip via the FDIO[15]. He would normally see the inbound information on the radar display about 10 minutes prior to the flight's arrival.

He stated that the ILS critical areas were being protected as required at the time of the accident. He felt that the airfield marking for pilot's awareness of the ILS critical areas were clear and easily visible, even during current construction. He understood the requirements for protection of ILS critical areas, and recited the 800 feet ceiling, and 2 miles visibility requirement. He further stated the 200-foot ceiling and 1.2-mile visibility inside of ½ mile requirement. He recalled one of the departure aircraft coming from the west side, and that they obtained releases for departures via STARS automation and would not release a flight until PHL ATCT accepted the STARS entry.

He said that coordination with PHL ATCT on the day of the accident was normal. As he recalled, the GC controller was attending to other tasks as N62UP continued inbound. He did not recall any discussion about N62UP not descending while on final, nor did he recall any discussion after the accident either. He would normally issue advisories reference right or left of course to aircraft on final.

He stated he would normally issue advisories with regards to azimuth deviations to pilots of aircraft on final. He stated he had seen other pilots execute a missed approach prior to reaching minimums before. He thought the lack of descent by a jet aircraft may have been odd, but not necessarily with a helicopter.

He recalled soliciting PIREPs around the time of the accident in accordance with FAA Order JO 7110.65, *Air Traffic Control*. PIREPs were being solicited all morning and were logged and tracked on a sheet of paper kept in the tower. He did state however, that only one of them was

[15] FDIO – Flight Data Input/Output - A system utilized to distribute flight plan information, weather information, and general information to associated ATC facilities across the NAS.

entered into AISR. His technique was to enter all the pilot reports into the AISR system, but admitted others were not as diligent. The FLM or the CIC were responsible to ensure PIREPs were entered into AISR. He did not know how PIREPs were handled during times when he was not in the tower. He said that ILG tower did not normally share PIREPs directly with PHL ATCT but did share them with other pilots on frequency that may be affected.

Interview concluded at 1145 EDT.

Interviewee: Amira Snow-Richardson, On-coming LC Controller
Representative: Nichole Vitale, Attorney for NATCA

Date / Time: June 1, 2017 / 1230 EDT
Location: ILG ATCT
Present: Heidi Kemner – NTSB, Ross Knoll – FAA, Eric Stormfels – NATCA, Cynthia Lowther – NATCA
Investigator: Brian Soper

During the interview Ms. Snow-Richardson stated the following:

Her air traffic control experience began in January of 2011 when she attended initial ATC training at the FAA Academy in Oklahoma City, Oklahoma. In April of 2011 she was assigned to Baton Rouge (BTR) ATCT and worked there until April of 2013 when she transferred to ILG ATCT.

She worked a rotating shift schedule with regular days off on Saturday and Sunday. Her work schedule for the week leading up to, and day of the accident was:

Friday	0615 - 1415	
Saturday	Off	
Sunday	Off	
Monday	1500 - 2300	
Tuesday	1200 - 2200	
Wednesday	0800 - 1800	
Thursday	0730 - 1530	(Day of accident)

She was the GC, FD, CD, and CIC controller combined to the GC position just prior to the accident and was being relieved by Mr. David Jordan. She then had some difficulty with the sign-on computer in the process of relieving Mr. Dubois as LC.

She was certified in April of 2014 and was current and proficient on the position she was working at the time of the accident in accordance with facility standards. She had no suspensions or documented operational incidents while at ILG ATCT. She was on the local safety council (LSC) and had not been on any recent details. She recalled nothing remarkable about the 72 hours leading up to the time of the accident, with routine daily activities, sleep, and meals.

On the day of the accident, she classified the weather being IFR with low ceilings, low visibility, and possibly misting. She had reviewed the audio replay of the event with staff prior to the day of this interview. She stated that no training was being conducted in the tower at or leading up to the time of the accident. On a scale of 1 to 5 (5 being the heaviest) she classified the traffic volume as 1 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as 1 at the time of the accident. She said that a relief briefing was conducted when she assumed the position, and that it was recorded, and a checklist was utilized. She did not perform toxicology testing as a result of this accident, and she did file an ATSAP report and had received confirmation of acceptance from the ERC.

Her operating initials were AR and her supervisor of record was James DuBois. She possessed a current second-class medical certificate and her last ATC physical had been conducted in April of 2016. She had no waivers or restrictions to her medical certificate. She held no other aeronautical ratings or certificates.

On the day of the accident, she was working her normally scheduled shift and was being relieved from GC, FD, CD, and CIC combined and was assuming LC. She had some trouble with the sign-on computer when trying to sign-on. S enlisted the assistance of Mr. DuBois who helped her troubleshoot the problem, after which she assumed the LC position. Before actually receiving the PRB for LC, the pilot of N62UP checked in on the ILS approach to RWY 1. She cleared N62UP to land on RWY 1, after which Mr. DuBois returned and provided her with a position relief briefing. The only traffic he passed down at the time was N62UP. Once she had received the relief briefing, as she began to "get her bearings", the pilot of N62UP called and requested the missed approach. She then coordinated with PHL ATCT as required for missed approach instructions, and the controller at PHL instructed her to use the published missed approach procedure. She then instructed the pilot of N62UP to fly the published missed approach, however there was no response. She looked up at the radar display and seen the data tag on N62UP go from 2,100 feet msl directly to CST[16]. After another attempt to contact with no response, both she and the FLM observed black smoke in the direction from which N62UP was approaching and the FLM instructed the GC to activate the crash phone.

She elaborated a little about her recollection of N62UP and stated that when he first called up she looked up and seen him at 2,100 feet msl and did not think much of it. She stated however, that right after initial contact with N62UP she became focused on taxiing two aircraft to RWY 1, one on each side of the runway, and was concerned about one aircraft possibly being in the ILS critical area.

She said that ILG ATCT had a good working relationship with PHL ATCT. When soliciting PIREPs, she said that all pertinent information was passed to PHL ATCT via landline. All PIREPs were passed to the FLM/CIC who was responsible to enter them into AISR. There had been much discussion at ILG ATCT about how PIREPs were disseminated throughout the NAS. When asked about the types of weather sources available to her for checking weather at the

[16] CST – Coast Track – Status of an aircraft that is no longer giving a primary radar return. This will generate a track message on the air traffic controllers radar display utilizing the acronym "CST" and will temporarily continue displaying the aircraft's predicted movement based on the last known heading and speed.

beginning of a shift, she said there were several weather-related websites bookmarked on the computer that she would go to and review when she was coming on shift.

She said that staffing of supervisors in the tower was more often covered with a CIC than it was with an FLM.

Interview concluded at 1335 EDT.

Interviewee: David Jordan, On-coming GC, FD, CD, and CIC Combined Controller
Representative: Nichole Vitale, Attorney for NATCA

Date / Time: June 1, 2017 / 1500 EDT
Location: ILG ATCT
Present: Heidi Kemner – NTSB, Ross Knoll – FAA, Eric Stormfels – NATCA, Cynthia Lowther – NATCA
Investigator: Brian Soper

During the interview Mr. Jordan stated the following:

His air traffic control experience began the USAF where he served as an air traffic controller from 2002 until his honorable discharge in 2006. He was a direct hire by the FAA in October 2007 and was assigned to ILG ATCT.

He worked a rotating shift schedule with regular days off on Friday and Saturday. Her work schedule for the week leading up to, and day of the accident was:

Friday	Off	
Saturday	Off	
Sunday	1500 - 2300	
Monday	1400 - 2200	
Tuesday	1000 - 1800	
Wednesday	0715 - 1515	
Thursday	0615 - 1415	(Day of accident)

He was the on-coming GC, FD, CD, and CIC controller combined to the GC at the time of the accident and had just relieved Ms. Snow-Richardson.

He was certified in January of 2008 and was current and proficient on the position he was working at the time of the accident in accordance with facility standards. He had no suspensions or documented operational incidents while at ILG ATCT. He was the recurrent training cadre and had been on a brief detail to PHL ATCT for a few days in January of 2017. He recalled nothing remarkable about the 72 hours leading up to the time of the accident, with routine daily activities, sleep, and meals.

On the day of the accident, he was working his normally scheduled shift. He recalled the weather being around a 400-foot ceiling with low visibility and did not think it was raining but

was not certain. He had reviewed the audio and video replay of the event with staff prior to the day of this interview. He stated that no training was being conducted in the tower at or leading up to the time of the accident. On a scale of 1 to 5 (5 being the heaviest) he classified the traffic volume as 3 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as 4 at the time of the accident. He said that a relief briefing was conducted when he assumed the position, and that it was recorded, and a checklist was utilized. He did not perform toxicology testing as a result of this accident and did not file an ATSAP report.

His operating initials were DJ and his supervisor of record was James DuBois. He possessed a current second-class medical certificate and his last ATC physical had been conducted in April of 2017. He had a requirement to wear corrective lenses while performing ATC duties, and stated that he was wearing them at the time of the accident. He had no other waivers or restrictions to his medical certificate. He held no other aeronautical ratings or certificates.

He recalled that he had taxied an aircraft to RWY 1 and had instructed the pilot to hold short of the ILS critical area on the taxiway. He said that it was very easy to see the ILS critical area markings on the taxiway. When asked if he would watch an arriving aircraft all the way to touchdown when was working LC, he said that he did probably only half the time due to other things that were going on in the tower environment. He said the FLM would routinely get time on position to help the controllers receive the extra 10% CIC pay.

He recalled that upon relieving Ms. Snow-Richardson, he was fairly busy with IFR clearances and remembered a flight going around and remarked that he thought it was strange for an aircraft to go around on a two-mile final. After hearing the go-around, he recalled looking at the radar display and not seeing any traffic on final and asked the LC where the aircraft was. Not knowing where it had gone, they began scanning the runway and did not observe anybody there. Around that time, the oncoming FLM had arrived in the tower to relieve the current FLM and seen black smoke in the direction from which N62UP had been approaching. The FLM then asked him to activate the crash phone and pass all the information.

He said that PIREPs were passed from LC to GC/CD (who is frequently the CIC) for further dissemination and entry into AISR. A lot of times the GC/CD controller would hear the PIREP being passed and just enter it in on their own. When traffic was busy, it had the potential to delay entry into AISR, but he felt that was rare. If a PIREP had reached an hour or older before being put into AISR, he would normally just not put it in. If he had any questions about the daily weather, he just looked at the ASOS on NIDS before assuming the position and would sometimes look at the Terminal Area Forecast (TAF) on the National Weather Service (NWS) website.

Interview concluded at 1605 EDT.