Factual Report – Attachment 2

Interview Summaries

AIR TRAFFIC CONTROL

DCA17FA109

Interviewee: Richard Wallace, Certified Professional Controller (CPC)
Representative: Erina Hammond, NATCA attorney
Date/Time: May 8, 2017 12:00 EDT
Location: CRW
Present: Chauntel Seiler, FAA SME, AJI-13, Timothy Keck, NATCA ASI, CLE ATCT
Investigator: Dan Bartlett

During the interview Richard Wallace stated the following:

He started his career with the FAA in December of 1992 at Myrtle Beach Tower (MYR) where he was a certified professional controller (CPC). In November 1995, he transferred to Washington Center (ZDC) where he worked until 2014 when he transferred to CRW. Prior to the FAA, Mr. Wallace worked as a controller in the US Air Force at MYR from 1987-1992 where he was qualified on all operating positions. His class 2 medical certificate was current, and he stated he had no waivers or restrictions; however, a restriction to have corrective lenses in his possession while performing ATC duties was verified upon review of his class 2 medical certificate. As the certificate was reviewed after the interview, the group was not able to query whether he had corrective lenses in his possession prior to the accident. His operating initials were WZ.

His work schedule for the week leading up to and including the day of the accident was:

Saturday Regular day off (RDO)
Sunday RDO

Monday	1000-1800
Tuesday	0745-1545
Wednesday	0815-1615
Thursday	0645-1445
Thursday	2300-0700 Friday morning (the accident occurred Friday morning)

The tower had been operated as a TRACAB (meaning all tower and radar ATC functions were combined to the tower) until approximately 0515 when he opened the TRACON following his break. Upon opening the TRACON, he assumed the duties as the overall controller-in-charge (OCIC) from the tower controller. He did not communicate with or provide ATC services to the accident aircraft and was not aware of what might have led to the accident.

It was the local controller's responsibility to record a new ATIS broadcast when weather changes warranted. On a mid-shift, one controller is typically in the tower working all positions in a TRACAB configuration while the other is on a recuperative break. He and Chris Lawrence were assigned the mid shift that night and he was relieved by Brent Garrett, at 0630, who provided ATC services to the accident aircraft.

He did not recall the weather conditions prior to the accident or if any PIREPs had been solicited or received. He was able to recite the PIREP requirements verbatim from the 7110.65 with no issue.

The ASOS in the tower beeped when there was new weather available however, he was in the TRACON when this occurred. He had been certified as a limited aviation weather reporting station (LAWRS) observer for more than 20 years and didn't know of anyone who was currently LAWRS certified at CRW. The manual ATIS at CRW was the only ATIS system he had ever known and had never worked with any type of digital ATIS.

When PIREPs were received, they were called into Elkins Flight Service, but they didn't always answer. In that case, PIREPs were written down and entered into the local information display system (IDS)

He didn't know that the high voltage was off on the ASR 8, it was not indicated on the radar control panel. He told Brent and Joel during his relief briefing that he had not seen any weather or primary radar targets on the radar display. He didn't touch the high voltage, but someone had reset it. He didn't recall hearing any aural alarm indicating a channel failure or any other power issues that evening.

The facility had recently received the Standard Terminal Automation Replacement System (STARS) and was preparing to transition to FUSION mode in the next week. Once on line, there would be two long range radars, Higbee and Bradford, in addition to the CRW ASR 8 and ADS-B input to the CRW terminal radar system.

He believed runway 23 was the calm wind runway and he had no knowledge about one of the accident pilots having a previous issue with ATC.

If the approach was below minimums, it's the pilot's choice at decision altitude to determine if they should continue the approach or go around. If the weather had changed while the aircraft was on the approach he would inform the arriving aircraft. He did not recall if he had ever done that at CRW.

He didn't know the crash happened until he was on his way home following the mid-shift

The interview concluded at 1250 EDT

Interviewee: John Lawrence, Local Controller (LC)
Representative: Erina Hammond, NATCA attorney
Date/Time: May 8, 2017 1515 EDT
Location: CRW
Present: Chauntel Seiler, FAA SME, AJI-13, Timothy Keck, NATCA ASI, CLE ATCT
Investigator: Dan Bartlett

During the interview John Lawrence stated the following:

He started his ATC career as a controller in the US Navy from 1996 to 2002. He was a controller at Naval Air Station Whidbey Island; Naval Support Facility Diego Garcia, British Indian Ocean Territory; and aboard USS Abraham Lincoln, (CVN-72). He started his career with the FAA in April of 2003. He started his FAA career at the ATCT/TRACON facility at Monroe Louisiana (MLU) from 2003 to 2009 and had been at CRW since 2009.

He was qualified on all positions in the ATCT and TRACON at CRW. These included ground control (GC), local control (LC), and flight data/clearance delivery (FD/CD) in the tower; radar north (RN), radar south (RS), Beckley radar, radar coordinator (R CI), and TRACON flight data. He was a on the job training instructor (OJTI) and a controller-in-charge (CIC).

His class 2 medical certificate was current with no limitations, waivers, or restrictions however; he wore corrective lenses and was wearing corrective lenses on the evening of May 4 and morning of May 5. His operating initials were CL.

His normal work schedule for the week leading up to and the day of the accident was:

Sunday	RDO
Monday	1345 to 2145
Tuesday	0730 to 11530
Wednesday	0645 to 1345
Wednesday	2300 mid-shift to 0700 Thursday morning
Thursday	2300 to 0700 Friday morning.
Saturday	RDO

He was working the mid-shift on the evening of May 4/morning of May 5 and was in the tower just prior to the accident occurring.

His supervisor for the past several years had been Paul Johns, the acting ATM.

On the mid-shift and until 0515 each day, all ATC positions in the facility were combined and located at the local control position. The mid-shift included two controllers from 2300 to 0645 with one controller on a recuperative break and the other controller staffing the positions in the tower. He was the only controller in the tower from approximately 0215 until he was relieved at approximately 0645 by Joel Jenkins. His coworker, Mr. Wallace, had been on a recuperative break and opened the TRACON after his recuperative break at approximately 0515.

At approximately 0515 he noticed that the radar presentation in the tower did not appear to be operating normally. It was not displaying weather and precipitation which was unusual considering that there were SIGMETs[1] in the area. He shared his concerns with the radar controller, who was also the CIC, and considered the issue addressed. He did not hear any alarms or see any indication on the tower radar control panel of any discrepancies with the radar. He did not recall any other equipment issues during his shift.

Traffic on the mid-shift usually included one or two arrivals in the first hour of the shift and then no traffic until approximately 0500 when traffic began to pick up. There were no arrivals before SNC1260 and a regularly scheduled daily departure by PDT4825 just before he was relieved at 0645.

The ASOS would alarm for 30 to 45 seconds when a new observation was being reported. This alarm could be silenced/muted, but it is not something that he would ever do. The ASOS alarmed at 0630 which was a special observation changing the airport weather conditions from VFR to IFR. He did not update the ATIS because, looking out the window, he observed good light, variable ceiling and he figured that the weather would change again in a short time because that was how the weather worked at CRW. It was a judgment call not to update the ATIS. He was relieved shortly thereafter. The ATIS was not updated with the 0630 special observation.

According to the standard operating procedure (SOP) the ATIS recording was to be verified by second person in the tower, if available, prior to the ATIS message being broadcast. ATIS information November was being transmitted prior to the accident. The ATIS transmission was cut short and did not include NOTAM information. He thought he had listened to and verified the ATIS November transmission but must not have.

PIREPs were forwarded to the flight service station for entry into the national database. Forwarding the PIREP information was the responsibility of the TRACON data controller during the day and the controller on watch in the tower during the mid-shift. Mr. Lawrence did not solicit or transmit any PIREP information during his shift. He believed that weather warranted solicitation of PIREPs, but he guessed he just forgot to do it.

[1]SIGMET – Significant Meteorological Information - A weather advisory issued concerning weather significant to the safety of all aircraft. SIGMET advisories cover severe and extreme turbulence, severe icing, and widespread dust or sandstorms that reduce visibility to less than 3 miles.

The interview concluded at 1615 EDT.

Interviewee: Joel Jenkins, Local Controller (LC)
Representative: Erina Hammond, NATCA attorney
Date/Time: May 9, 2017 10:15 EDT
Location: CRW
Present: Chauntel Seiler, FAA SME, AJI-13, Timothy Keck, NATCA ASI, CLE ATCT
Investigator: Dan Bartlett

During the interview Joel Jenkins stated the following:

He started his career with the FAA in March of 2014 at CRW as a CPC. Prior to the FAA, he attended The Community College of Beaver County. He was qualified on all operating positions at CRW and his class 2 medical certificate was valid, and he had no waivers or restrictions. His operating initials were JP.

His work schedule for the week leading up to and the day of surrounding the accident was:

Sunday	RDO
Monday	RDO
Tuesday	1515-2315
Wednesday	1345-2145
Thursday	1345-2145
Friday	0645-1445

He was scheduled to work the mid-shift from 2300 on Friday to 0700 Saturday, but was given administrative leave due to the accident.

He liked this schedule and did not have any fatigue issues. Overtime was not too common; however, he did work for overtime credit hours frequently, usually in 15-45-minute increments. He was the facility recurrent training cadre representative and his supervisor was Jeff Douglas.

On the day of the accident, he had arrived at work and relieved Mr. Lawrence around 0641 from the local control position in the tower. He received a position relief briefing which included information about a vehicle on the taxiway conducting an inspection and that PDT4825 had been cleared for takeoff from runway 5. He switched PDT4825 to departure. He didn't recall hearing any information in the position relief briefing about radar issues.

SNC1260 contacted the tower on the VOR-A approach. He issued the wind and cleared the aircraft to land. He said that the low altitude alert (LA) alarmed, at which time he issued a low altitude alert to the pilot, telling her to check her altitude immediately and issued the CRW altimeter. The pilot responded that they could go down to 1,600 MSL but their altitude at the time was 2,200 MSL. He commented to the pilot that it may have been the rate of descent that caused the LA to alarm. The LA alarmed a couple more times but thought it may have been part of the

same issue that caused the initial LA to alarm, so he didn't restate the low altitude alert. When asked if there was anything else he should do, Mr. Jenkins said that he pulled out the approach plate and double checked the altitudes but since the pilot was within the confines of the approach chart there was nothing else to do.

He looked out the window and could see the aircraft lights from SNC1260 between 3 to 4 miles from the airport, but the aircraft reentered clouds and he lost sight of it. When SNC1260 broke out of the clouds again it was close to the airport and higher than normal for that part of the approach. When the aircraft reappeared, it started down and made a sharp left turn towards the runway where the left wing impacted the runway. The plane hit sideways, a wing broke off and the rest of the aircraft went over the hill. He initially thought the aircraft was going to go-around because they were too high and too close to the airport. The aircraft appeared to be in the correct position in relation to the final approach course.

His next steps were reaching for the claxon (siren) as he was trying to watch the plane. At that point, Nick Baker who was working CIC, GC, FD rang the siren and notified the CRW Aircraft Rescue and Firefighting (ARFF) via telephone because the "crash phone" was out of service. He immediately took over the GC frequency so that Mr. Baker could make appropriate notification calls and an airport vehicle checked on the frequency. He sent the airport vehicle towards the aircraft, crossing runway 5 and told the vehicle operator that the accident site was ahead and to the left of the vehicle. He called down to the TRACON on the ETVS[2] and advised the overall controller in charge (OCIC) of the aircraft accident. In his opinion, the ARFF response was timely. The claxon had been at CRW for longer than he had, and it was a siren mounted outside that could be heard all over the airfield.

He was relieved from position about 15 minutes after the accident. The ground controller was relieved after he was but was unsure how much later.

Since the accident, he had become aware of the fact that the weather was below approach minimums but wasn't aware of it at the time of the accident. He wasn't sure if the airport was IFR when he took the position. When he briefed the CIC/GC he looked at the ASOS and realized it was IFR. When he took the position in the tower, he had assumed the weather was up to date on the IDS and ATIS. Nick Baker, who opened GC and assumed tower CIC duties came up just a few minutes behind him.

He recited the 7110.65 requirements for PIREP solicitation but did not recall the April 2017 change to the 7110.65 changing priority and other elements of PIREP and weather receipt and dissemination. He did not solicit a PIREP from PDT4825 because he forgot. The SOP required LC to switch departures to the departure controller between ½ and 1 mile from the runway. He would normally ask the departing aircraft to pass base and top reports to the departure controller. The radar and tower controllers would normally exchange pertinent PIREP information between one another.

The ATIS should contain runway in use, approach information, NOTAMs, weather, and should be issued in a timely manner. The SOP required the controller to review the ATIS for

[2] ETVS - enhanced terminal voice switch (communication console)

correctness and quality. When he recorded an ATIS broadcast, he always reviewed it before transmitting it. The computer would beep around :48 minutes past the hour indicating a new observation was pending. It would beep again at :54 minutes past the hour to indicate the observation was transmitting. The ASOS alert could be defeated via a keystroke function. He did not use that function and had not seen anyone else use it because he didn't know who might relieve him and they may need that reminder alert. He stated that the ASOS and the ATIS were independent of each other. False ASOS alerts happened often, for example an hourly observation would have a correction or a special pending then it would cancel out. He did have a direct button to the contract weather observers on the ETVS to make amendments to the ASOS observation if necessary.

Aircraft moving on the airfield were the priority especially over recording a new ATIS. He would take care of the aircraft prior to recording a new ATIS broadcast.

He did not recall hearing an emergency locator transmission (ELT)[3] on guard frequency 121.5. The TRACON controllers normally monitor the guard frequency but, during the midnight shift, the tower would monitor it.

On his drive in to work on the day of the accident, he noticed low clouds, but when he got to the tower, he noticed there was no weather displayed. Checking the radar control panel, he noticed the radar high voltage (HV) button was off by checking each line of lights and noticing the difference. The HV lights were illuminated but did not see any red lights indicating a failure and there was no aural alarm for a failure. The radar control panel was on the back wall of the TRACON and would sometimes drop one of the two channels offline needing reset. He stated that he called down to the TRACON to Mr. Garrett on the telephone to check the radar HV.

The interview concluded at 1140

Interviewee: Brent Garrett, Radar South Controller (RS)
Representative: Erina Hammond, NATCA attorney
Date/Time: May 9, 2017 1405 EDT
Location: CRW
Present: Chauntel Seiler, FAA SME, AJI-13, Timothy Keck, NATCA ASI, CLE ATCT
Investigator: Dan Bartlett

During the interview Brent Garrett stated the following:

He started with the FAA in 2006 after attending initial training and was assigned to Indianapolis Center (ZID) from 2007 to 2009. He worked at CRW from 2009 to 2010 after which he became a federal air marshal operating out of Miami, Florida. In 2014 he returned to CRW as a controller where he has worked since. He was qualified on all positions in the facility and designated an OJTI and CIC. His operating initials were BX.

[3] ELT – Emergency locator transmitter - carried aboard most aircraft in the U.S. In the event of an aircraft accident, these devices are designed to transmit a distress signal on 121.5, 243.0-megahertz frequencies (and for newer ELTs, on 406 MHz).

His work schedule during the week leading up to and the day of the accident was:

Sunday	0000 to 0800
Monday	RDO
Tuesday	RDO
Wednesday	1400 to 2200
Thursday	0800 to 1600
Friday	0645 to 1445
Friday	2300 to 0700 on Saturday

He rarely worked overtime and would occasionally use Fridays to accomplish tasks associated with his duties as the NATCA facility representative.

His class 2 medical certificate was current with no waivers or restrictions. His supervisor for the last five months was Jeff Douglas.

On the morning of the accident, he arrived in the TRACON and was provided a position relief brief at approximately 0630 by Mr. Wallace, who was just finishing the mid-shift. He did not recall any particular weather information during the briefing. Mr. Wallace left the radar room 3 to 5 minutes after the briefing and was not in the radar room when the accident occurred.

He was working traffic that included a Night Cargo flight, other than the accident aircraft, going to the Beckley airport. He accepted a radar handoff from Huntington approach on SNC1260 and the pilot advised on initial contact that she had ATIS information November. He issued the altimeter and advised the pilot to expect a vector to the localizer approach to runway 5. The pilot acknowledged the altimeter setting and requested the VOR-A approach. Having never approved what he considered the unusual request for a VOR-A approach to a landing on runway 5, he hesitated, checked the weather and noticed ATIS information November and assumed it was current with a 500-foot ceiling. He approved the request and directed the pilot to proceed direct to the VOR at 4,000 or 5,000 feet, he could not recall which altitude he assigned. The VOR-A approach was usually used for training approaches and he could not recall a pilot requesting the approach to land on runway 5.

The initial heading he issued to the pilot of SNC1260 was a direct vector to the VOR instead of via one of the fixes for the approach. He did not have the VOR-A approach map displayed but really didn't need it as the approach was a pretty much a straight shot to the VOR and then to the airport. He did not normally depict the approaches on the radar video map since he was pretty familiar with where an aircraft should be on a given approach. He did not recall observing other controllers use the specific maps associated with the approach. It was standard procedure to clear aircraft for the VOR-A approach via direct to the VOR.

When SNC1260 was approximately 12 miles from the airport, he directed the pilot to cross the VOR at or above 3,000 feet and cleared SNC1260 for the approach. The pilot acknowledged. He then cleared the other Night Cargo aircraft inbound to the Beckley airport for the ILS to runway 19 at Beckley and worked a Piedmont departure from CRW. The Piedmont departure was pretty

much a straight shot to the departure fix, so he was cleared direct to the filed fix, instructed the pilot to climb to 10,000 feet and to contact the center. He then instructed the pilot of SNC1260 to contact CRW tower on frequency 125.7. While SNC1260 was still about 10 miles from the airport, Mr. Garrett called the tower, and with winds being calm, suggested that the tower switch from runway 5 to runway 23. The tower called back and discussed switching to runway 23 after SNC1260 landed. He heard the low altitude alert alarm and monitored the local control frequency to ensure a low altitude alert was issued to the pilot properly. The local controller issued a proper low altitude warning. Low altitude alerts occurred frequently in the airspace SNC1260 was transitioning.

Shortly thereafter, he heard and felt SNC1260 crash. He initially thought the noise and vibration was caused by the occasional garbage truck that would pick up and drop off large trash bins outside the building. A few seconds later the tower called and advised there had been an aircraft accident. He immediately began emergency notifications using the emergency checklist in the emergency binder after he called 911 to report the accident. The airport was then closed. Another controller, Steve Richardson. arrived in the radar room and assisted with communications and coordination. There were no supervisors present and it was pure chaos. He was relieved from position about an hour and five minutes after the accident.

Normally the facility was pretty good about PIREP solicitation and dissemination, but they did not do such a good job that morning.

The crash phone had been out of service since approximately January 2017 and crash notification was reported directly to the ARFF, which was provided by the Air National Guard unit located on the airport. The ATIS had recurring problems when recording and often cut off part of a recording. Mr. Garrett would occasionally turn the ATIS off and provide the weather directly to the pilot, when he did not have time to make the multiple attempts it sometimes took to record an observation. The radar high voltage failure indication did not work properly when a power failure occurred and the lights that were supposed to indicate high voltage was off did not light up and there was no aural alarm when radar high voltage failed. ATSAP reporting was a method for addressing equipment issues in the facility.

The interview concluded at 1520.