Docket No. SA-538

Exhibit No. 2-B

NATIONAL TRANSPORTATION SAFETY BOARD

Washington, D.C.

Attachment 1 – Birmingham Interview Summaries
(30 Pages)

NATIONAL TRANSPORTATION SAFETY BOARD

Office of Aviation Safety
Washington, D.C. 20594

February 7, 2014

Attachment 1 – Birmingham Interview Summaries

OPERATIONAL FACTORS

DCA13MA133

Table Of Contents

A. BIRMINGHAM INTERVIEW SUMMARIES

1.0 Interviewee: Ronald Lane Orcutt, Birmingham Gateway Manager, UPS

Date: August 16, 2013
Location: UPS Birmingham Gateway Offices, Birmingham, AL
Time: 0915 Local
Present were: David Lawrence, National Transportation Safety Board (NTSB); Katherine Wilson, (NTSB); Normand Bissonnette, Federal Aviation Administration (FAA); William Middleton, Independent Pilots Association (IPA); Lawrence Ashby, United Parcel Service (UPS)

Mr. Orcutt was represented by Bob Wagner.

During the interview, Mr. Orcutt stated the following:

He was 57 years old. He was the Gateway Manager at the Birmingham Airport and had been since 2006. He had been with UPS since 1981. He had always worked in Birmingham with exception of 10 months when he worked at the Goodwater Center in Alabama. He oversaw all operations in Birmingham. The only interaction he would have with a flight crew was identification checks and providing the flight crew with the required flight departure paperwork.

Crews would introduce themselves. The Gateway had about 40 vendor employees and a handful of UPS employees who were mostly management.

He would not recognize the accident crew by name but might by their faces.

He was not present at the Gateway at the time of the accident due to his responsibilities at the Knoxville, Tennessee, gateway. Part time supervisor Jason Broady was on duty. Pilots would show up 1 hour before their departure. They would verify their IDs at the door and then they would start going through their paperwork and weather. It was mostly just conversational. Maintenance personnel would interact with them more. Maintenance in Birmingham was performed by UPS personnel.

He had not heard any issues or complaints about arrival procedures or operations Birmingham. He did not think he would be the one they would tell. He did not know of any problems reported to ops center.

Delays would be tracked by UPS and they looked at that every day. With regards to Birmingham aircraft arrival procedures the flight was normally on time within 10-15 minutes. Typical delays were due to the Louisville Hub or weather in Louisville or enroute; it was not normally Birmingham weather delays or runway configuration.

They received an in range ACARs message from the accident crew at about 0410 local time. Their estimated time of arrival was 0451. He was not aware of any issues reported by the accident crew and they requested that the hotel be called.

He would be notified that runway 6/24 was closed by the airport and that it was in the NOTAMs. Maintenance on the airport that would close a runway was not common. He had not heard any concerns about landing on runway 18/36 or about runway configurations into Birmingham.

He had not seen any pictures of the accident crew to know if he recognized them. He was not a pilot.

He had worked in other positions at UPS such as loading trucks, driving trucks, business development work, industrial engineering work, operations in the packaging center and gateway operations.

He was also in charge of Knoxville, a small feeder in Nashville, Huntsville and Birmingham. He lived in Birmingham so probably spent most of his time at that station.

He said it was very odd to use runway 18. In over 6 years, he only saw runway 6/24 in use. He has maybe seen runway 18 be used 1-2 % of the time.

They might receive calls in the PM if they were calling for a mechanic; calls in the AM would have been rare.

He was not aware of any calls from the accident crew.

He was not aware of any crew comments or concerns about runway 18.

He thought maintenance might have a radio but had not seen them use it at night; his department did not have one.

He had jumpseated before but had not done so in a few years.

The emergency response plan was kept in the office but it was not activated after the accident. It primarily dealt with adverse weather. The District had an emergency response team.

On the morning of the accident, they only knew that the airplane did not show. He thought ATC might have confirmed it. He was notified of accident by Bob Wagner. Ground crew go out to the ramp about 10 minutes prior to the airplane's arrival and saw something bright but they thought it was maybe from a local plant. They told him they did not know it was an airplane; there was no sound with the flash. A FedEx pilot told UPS ground crew that the aircraft had crashed.

He thought official notification of the accident to the Birmingham Gateway came from UPS flight control. Glen McKinney, his full time supervisor, was at the Gateway within 45 minutes and started taking the calls. He got notification from his boss and arrived at the Gateway about 1100 from Knoxville.

Interview concluded at 0949.

2.0 Interviewee: Jason Isaac Broady, AM Part Time Supervisor, UPS

Date: 16 August, 2013
Location: UPS Birmingham Gateway Offices
Time: 1016 Local
Present were: David Lawrence, NTSB; Katherine Wilson, NTSB; Normand Bissonnette, FAA; William Middleton, IPA; Lawrence Ashby, UPS

Mr. Broady was represented by Ronald Orcutt.

During the interview, Mr. Broady stated the following:

He was 42 years old. He was the Gateway AM Part Time Supervisor at the Birmingham Airport. His shift was from 0330 until 0800 or 0900. He had been with UPS since 1997. He started at the customer counter, in 1999 worked as an operations management specialist, and in 2005 he became the Gateway part time supervisor.

On the day of the accident, he was performing normal duties to include trailer load plans and ramp supervision. He walked outside to ramp at 0440 local and remained on the ramp until 0500 local. At 0500, he called the tower and was informed there was an airplane down but tower did not say it was UPS. He was told they had not confirmed which plane it was. He attempted to contact the accident airplane by radio but was unable to reach them.

He usually went outside about 10-15 minutes before the airplane was to arrive. The accident airplane was supposed to arrive at 0451. He saw over the horizon a red glow but thought it was the ABC Coke plant.

It was dark so he was not sure about the weather. There were little spurts of sprinkles. He did not remember the clouds. There was no rain and nothing unusual with the weather.

Standing with him outside were ground personnel.

He received the ACARs in range report at 0410 local that the airplane would arrive at 0451. He thought it probably said to call the hotel van.

It was always the Airbus that flew this flight into Birmingham unless Louisville changed it. The flight was usually on time.

He would interact with the crew when they come in and he would go in the airplane to put the "Do Not Operate Flaps" placard in the cockpit. There were no maintenance problems with the accident airplane that he knew of. His interaction with the crew was a general greeting with the crew. The crews never expressed any concerns to him about flying into Birmingham.

Airplanes normally landed on the long runway (6/24) and he has never seen a UPS airplane land on runway 18/36.

No other ACARs messages were received.

He attempted to access the Emergency Response Plan but was unable. He was looking for a book but he called Glen who told him that the plan was online. Glen told him to wait until he arrived at the Gateway.

He had seen the accident captain before but not the accident F/O. He thought he saw the accident captain last year; he believed he was an F/O then. The accident captain had a smile on his face. He had no unusual interactions with the accident captain. The accident captain never mentioned concerns about UPS.

He had seen the emergency response plan for the Gateway but it did not include an aircraft accident. There was no drill for an aircraft accident that he attended.

The interview concluded at 1035.

3.0 Interviewee: Cary Clayton Smith, Station Manager, General Aviation Terminals

Date: August 16, 2013
Location: UPS Birmingham Gateway Offices, Birmingham, AL
Time: 1038 CDT

Present were: David Lawrence, NTSB; Katherine Wilson, NTSB; Normand Bissonnette, FAA; William Middleton, IPA; Lawrence Ashby, UPS

Mr. Smith declined representation.

During the interview, Mr. Smith stated the following:

He was 35 years old. He was the station manager for General Aviation Terminals (GAT). He worked for UPS and Delta Cargo. He had worked in this capacity for UPS about 1 year. He had worked for Delta contracts on and off since 1998. In his position he oversaw the staffing and ground training for the ground crew that loads and unloads UPS aircraft. He was working the morning of the accident.

At approximately 0448, while walking out to wait for the inbound flight he witnessed a huge orange glow in the distance. It did not register to him that the "glow" could be an airplane crash. He thought something was on fire.

He and his crew waited for the aircraft to arrive. A FedEx flight landed and the pilot walked towards them. They met the pilot half way and he told him and the gateway that the inbound UPS jet had crashed. He asked the pilot to come inside and inform someone at UPS about what he had told him.

The weather was somewhat foggy and light drizzle started to fall while he and his crew were waiting for the UPS jet to arrive. They walked under the overhang. He did not notice the clouds.

There was no noise associated with the glow. When it first happened there were big flames then a glow. It was hard to see from their position.

He never interacted with the accident crew.

Normally the inbound UPS flight landed on runway 6 or 24. He had never noticed it not land there but he said "that's not my thing."

There was no action taken after he brought the FedEx pilot inside to talk to UPS. He did not see anything prior to opening the door; there was no "boom." He did not participate in any ERP.

He could see lights but really only noticed the orange ball from the accident. He did not look on the airport property. He could see some hills.

The interview concluded at 1047.

4.0 Interviewee: Maury Adams, Aircraft Maintenance Technician, UPS

Date: August 16, 2013
Location: UPS Birmingham Gateway Offices, Birmingham, AL
Time: 1130 CDT

Present were: David Lawrence, NTSB; Katherine Wilson, NTSB; Normand Bissonnette, FAA; William Middleton, IPA; Lawrence Ashby, UPS

Mr. Adams declined representation.

During the interview, Mr. Adams stated the following:

He was 49 years old. He was employed by UPS as an FAA certificated Aircraft Maintenance Technician. He had been a mechanic for 16 years. He mostly worked on the A300 but also worked on the DC-8 and B-727. In Rockford, he had worked on the B-757/767.

He was working at the UPS Birmingham airport ramp facility at the time of the accident. He was on the ramp waiting for the aircraft to arrive, and saw a big orange glow "over this way" (indicating the direction/location of glow). He could not recall the time he was out there but thought it was around the flight's arrival time. He did not think it was their aircraft and he talked to another ground guy saying he did not know what that was. He stood around some more, commented that the plane was late, and asked Jason Broady about any ACARS messages. He then went into the ramp office and called the airport authority and was told by a lady that there was a cargo plane situation. A few minutes later someone came up to him and said that it was their airplane.

He stated that the weather was fairly clear. There was no information on the ACARS or any voice communications with the accident flight crew/aircraft that he was aware of.

He had some previous interaction with the accident captain and had met him in 1998 when the accident captain was a flight engineer on the DC-8. He thought he had seen the accident F/O before but never really interacted with her. He recalled that the accident captain was a nice guy who was "always happy, upbeat, positive, never complaining." He last saw the accident captain briefly about a month ago, and had a casual conversation, "how are you doing", etc.

He did not recall the accident captain doing any maintenance write-ups. He did not recall any maintenance write ups on the accident airplane, and that there were not many write-ups on the A-300 in general at BMH, just the scheduled stuff.

It started raining, (light drizzle), on the ramp a short time after the aircraft crash.

He did not see a fireball after the crash but the sky got bright orange. He was not sure why there was an orange glow because he did not think a plane would land from over there. He knew there was a rock quarry over there.

Maintenance did not have an emergency response plan. He was not sure about Operations. He only reported the accident to his supervisor.

He did not recall anyone saying anything bad about the accident captain or F/O.

He worked in Rockford for 1 year prior to working in Birmingham.

Aircraft normally landed on runway 6/24, and he could not recall anyone landing on runway 18.

He typically did not listen to the live ATC radio in the office for inbound aircraft.

He held an A&P certification and was not a pilot.

The interview concluded at 1145.

5.0 Interviewee: Glenn Miller Tate, Aircraft Mechanic, UPS

Date: August 16, 2013
Location: UPS Birmingham Gateway Offices, Birmingham, AL
Time: 1147 CDT
Present were: David Lawrence, NTSB; Katherine Wilson, NTSB; Normand Bissonnette, FAA; William Middleton, IPA; Lawrence Ashby, UPS

Mr. Tate declined representation.

During the interview, Mr. Tate stated the following:

He was 60 years old. He was employed by UPS as an aircraft mechanic and had been for 25 years. He previously worked at EFD for 5 years, in St. Petersburg for 1 year, and Pensacola in 1 year. He was qualified on the A300, DC-8, B727, and B757/767.

He was working at the UPS Birmingham airport ramp facility at the time of the accident. He was scheduled in at 0500 but arrived in the office at approximately 0445. Mr. Adams was on the ramp and came into the office concerned about a plane crash about 0500. Mr. Adams called the tower and the confirmed it. A FedEx captain came into the office and confirmed he saw the UPS airplane crash, but Mr. Tate did not talk to him.

There was no ERP (Emergency Response Program) for maintenance.

He did not remember the accident F/O, but he knew the accident captain was a retired US Marine and Mr. Tate had a Marine Harley. The accident captain was a nice guy. They chatted regular guy talk, and said the accident captain had been coming here for years as a B727 FO.

Mr. Tate was gone from Birmingham for 2 years and returned in March 2013. Mr. Adams usually met the arriving crew in the AM. Mr. Tate would see them at night.

He had never heard the accident captain have any complaints about flying the Airbus, the company or the routes.

The A300 had no maintenance issues per se, just the usual stuff for airplanes. He had heard about a leading edge issue but that was during the period when he was gone. He thought UPS was good about their maintenance.

He usually got a printout of the ACARS but not for the accident flight; he did not see an in range message. He had no voice communications with the accident aircraft/crew. He did not have a radio so he would not have heard any voice communications. Only ops had a radio.

He remembered a DC-8 landed on runway 18 5-6 years ago and that the female pilot was "shook up". She said she would not land on that runway again; it was too short. Mr. Tate thought the runway sloped up and it was kind of a tough runway.

Sometimes runway 6/24 was closed in the early AM, and that Southwest and others had to land on runway 18. He was not sure if the accident captain had ever landed on runway 18. He did not believe the accident captain had. Southwest airplanes landed on runway 18 night and day.

His facility used to be closer to the main terminal.

He last saw the accident captain about a month ago. There was nothing unusual about the interaction and they discussed Mr. Tate's motorcycle.

The weather on the morning of the accident was clear, nice nothing unusual. He did not notice any rain or fog.

FedEx airplanes landed on runway 6/24.

The interview concluded at 1200.

6.0 Interviewee: Michael Craig Willetts, Captain, UPS

Date: August 16, 2013
Time: 1815 CDT
Location: via teleconference
Present were: David Lawrence, NTSB; Katherine Wilson, NTSB; Normand Bissonnette, FAA; William Middleton, IPA; Lawrence Ashby, UPS

Capt. Willetts declined representation.

During the interview, Capt. Willetts stated the following:

He flew the A300-600 and was type rated on the A310. He had about 13,000 total time, and about 4500 hours on the A300. He had been with UPS since 1990.

He saw the accident captain on Monday, August 12, 2013, when he was a jumpseater on Capt. Willetts' flight from Charlotte to Louisville. The flight departed about 2215 local and arrived about 2330 local time.

The A300 can accommodate up to 5 jumpseaters.

He also saw the accident captain the week prior to the accident.

On August 12, he first saw the accident captain about 2115-2120 in the briefing room. The accident captain was there with 2 other jumpseaters and his first officer, F/O Pearce. They had normal conversation. Capt. Willetts knew the accident captain well and knew his family. They both had daughters about the same age and they spoke about that.

The accident captain was extremely alert and impeccably dressed. He was wearing a Marine Corp lanyard. The accident captain took his profession very seriously. The accident captain did not show any signs of being tired.

He had known the accident captain since 1996 when he thought the accident captain was flying a different aircraft. When Capt. Willett became a captain in 2001, he and the accident captain flew together a lot out of Raleigh to Louisville. At the time, the accident captain was an F/O. They did not associate much outside of work at that time because Capt. Willetts lived far away but they had a friendly relationship and a good working relationship.

He did the OE for the accident captain in the Airbus a few years previous.

On the August 12 flight, the accident captain was seated in the supernumerary. From where he sat in the cockpit, he could only see one jumpseat. He thought the accident captain was seated in the second or third seat. After landing in Louisville, they boarded the van and had casual chit chat. When they got to the ops area, the crew rest beds were first come first serve. Capt. Willetts got a bed and he assumed the accident captain did the same. The accident captain was flying to Rockford.

While in Charlotte, he thought the accident captain told him that he had taken a sick call and that was why he was jumpseating. The accident captain was known to pick up trips. He did not know if the accident captain actually called in sick and was making up a trip or just said he did to explain why he was picking up a trip. The accident captain did not look sick. The accident captain always "looked the part" of a pilot.

He saw the accident F/O on Tuesday night in Louisville. His flight was scheduled to leave about 0210 but he did not know when the accident crew's flight was scheduled to leave. He knew the accident crew got sleep rooms but he did not know if the accident captain was there when he saw the accident F/O. He saw the accident F/O in the briefing room in Louisville. There was a main counter in the room with various support staff located at it. The accident F/O was talking to someone at the end when he saw her.

He knew the accident F/O well because he did her training when she got to the Airbus and since then she would call him with questions about the Airbus and personal issues.

Capt. Willett left his sleep room about 0110 so he thought he saw her about 0120-0125 and they talked until about 0150. They discussed her weekend layover and it was a good conversation. She said she jumpseated from San Antonio on Saturday to Houston to meet some friends and

stated she was "intoxicated" from then until early Monday morning, August 12. He did not see the accident F/O until Tuesday, August 13.

The accident F/O had previously indicated to him that she and her husband were having some problems in their relationship but since February 2013 things had improved. The accident F/O downplayed the role of her husband at the Jack Daniels Distillery and he did not know that he was an executive with the company; she only told him that he worked there.

On Tuesday, the accident F/O spoke of her mom and dad and her horses. She was good friends with another F/O, Billy Moody. They were like brother and sister. After the accident, Capt. Willett talked to her parents and also F/O Moody who had called in sick for a trip because he was distraught. F/O Moody saw the accident captain on Tuesday because she was giving him the keys to her car which he drove to his home on Wednesday after his trip ended.

He knew that the accident F/O had a key for a sleep room but did not know if she used it to nap. He also knew that the accident captain had a sleep room key. The accident F/O seemed alert and ready to go to work.

The accident F/O did not mention any concerns about flying into Birmingham. He thought Birmingham was a common everyday airport, but it was not a common route that the accident F/O flew. She was a junior F/O.

Capt. Willett said another F/O, Michael Trammel, flew in and out of Birmingham and had talked with the accident F/O on Monday or Tuesday before the accident.

The accident F/O was alert on Tuesday and he had no concerns about her.

The accident F/O never called him to ask him about flying with the accident captain. He was not sure how many times the accident crew had flown together. When he saw her on Tuesday she did not mention that she was flying with the accident captain.

He performed the accident F/O's OE on the Airbus in June 2012 and of the 25 hours she received, they flew about 20-21 of those hours together. OE was the first time that they had flown together.

Capt. Willett was still a check airman on the Airbus and had been for about 10 years except for a short time when he was removed from the position during contract negotiations.

Union pilots do all checks except the sign off which was done by company (management) pilots.

He recalled her well. He had trained F/O Moody who had suggested to the accident F/O that she contact him directly prior to her OE, which she did.

He flew with the accident F/O for multiple legs every night. She was coming off the B747-400. He thought if you can fly the 747, you can fly about any airplane.

The accident F/O was described as a "competent pilot." There were times that he would hear that she had said she would fly with other captains who wanted her to do things differently and she would just go with the flow with them.

When he flew with a pilot during OE, he tried to let them fly as many of the legs as they would like because they were new to the airplane and to get as many takeoffs and landings as possible. Multiple takeoffs and landings make a difference.

There was nothing in his trip book that made him uncomfortable with the accident F/O's training or anything that she did. She was a satisfactory student but there was nothing that told him she was an above normal student. As long as he had been doing this, he could easily recognize those students that were "sharper than others". He knew the accident F/O was the type of pilot who was not as eager to hand fly the airplane as he would have like to have seen in training. She would turn on the autopilot as soon as she could. There was nothing wrong with that but he encouraged her to hand fly more. He knew that was the way she was. As OE progressed, she got more comfortable hand flying the airplane.

After OE, he flew with the accident F/O quite a bit but it was not recently. As a PM, she was very alert, did not miss any radio calls and her call outs were standard. There was nothing brought to his attention that he would have to brief her on. He last flew with her probably in winter 2012.

He did not remember if they shot any non-precision approaches during OE. He thought they probably did a lot of visual approaches, straight up ILS, and maybe a 1-2 GPS approaches. He thought they probably always flew straight up ILS approaches or visual approaches. He had done OE training into Birmingham but could not remember if it was with her. During OE, when she finished flying with him, she was moving to her "release to the line" check. The accident F/O was uneasy about flying into Albuquerque because UPS had a tail strike there in the past. It was a slightly high elevation airport and mountainous terrain off to the east. She called Capt. Willetts about the trip prior to being released to the line. He briefed her on how to handle and deal with that airport. He also thought he had flown with her on the same trip.

He had never landed on runway 18 or 36 at Birmingham, only 6/24. He had flown the Airbus for about 12 ½ years and probably had been in to Birmingham 15-30 times. He was fairly comfortable with the airport itself and the controllers there.

Asked if any students had difficulty in line operations with non-precision approaches such as localizer approach using a VNAV PAPI descent as opposed to vertical speed, he said they did not use the VNAV in the Airbus; they used profile. It was clarified that the VNAV was defined on the localizer approach to runway 18. It was tough for him to recall. He thought there was always some uneasiness in that anytime it was not a straight up ILS approach and do something that was non-standard approach or not something that was done all of the time, pilots had a more heightened awareness.

SOPs at UPS indicated either pilot could call for a go around at any time. They had a no fault go around policy. Asked if the accident F/O would call for a go around, he said he could not give an

honest answer. He thought if the flight was not exactly on parameters at 1000, she would not call for a go around. But if the flight was in dire straits, she would execute or call for a go around.

He had flown with the accident captain a lot when he was Capt. Willets' F/O. He got to know him a little more. The accident captain had time in the military. They had flown numerous times out of Raleigh and the accident captain was a very well prepared crewmember; he would show up prepared to go to work and training. Capt. Willetts did not think those two things necessarily went hand and hand with showing up to fly the airplane. The accident captain was a capable pilot but as an F/O he was new to the airplane and would try to get the autopilot on as soon as he could and leave it on as long as he could. They flew Raleigh trips all of the time. He recalled a time when shooting the visual approach and the accident captain would pay attention to his heading and the localizer rather than where the runway was and the airplane would overfly the runway rather than the accident captain flying it and turning it towards the runway. His approaches would always be stabilized and standard. It was just that the accident captain's aviation skills were not how pilots at UPS would generally fly airplanes. In typical line operations, they did not fly the box pattern. Pilots flew as expeditiously as possible because "time is money" but pilots were always being safe. They always operated within the parameters of the operations manual and procedures. The accident captain was "not the sharpest tack in the box" in his aviator skills as an F/O; he spent a lot of time as an F/O. The accident captain wanted to be as comfortable as he could be before he transitioned to the left seat. During OE, Capt. Willetts knew the accident captain was in the airplane a long time. His comfort level was higher flying with the accident captain because he had 1000-2000 hours on the airplane when compared to the accident F/O because she had few hours on the airplane. He knew he would not have to concentrate on the accident captain as much because he has experience in the airplane.

He last flew with the accident captain or observed him flying within the last week. They lived in the same gateway area, so he was either in the jumpseat with the accident captain or vice versa. He thought he flew with him in the last week or 2 weeks in one aspect or another. If Capt. Willetts was sitting in the supernumerary, he would tend to sit in the seat closest to the entry door. He could not recall the last time he sat up in the forward observe seat watching him do his job directly.

He did not see the accident captain on Tuesday night, but he saw him on Monday night.

The accident captain was a "poster child" for sticking to SOPs. His assumption was that the accident captain would have briefed well going into Birmingham. There were no indications of terrain on the approach but on the approach plate there was a dot with a note on the side to indicate it. He thought a normal pilot would have missed it.

Asked if when flying with the accident captain there was a time that they were rushed, he recalled when flying out of Raleigh when given the visual approach, a pilot would have to "pick yourself up a little bit," such as turning on to final at the outer marker. The accident captain was not the type that was comfortable doing that. It might have been because of his experience level at that time. Years ago when they were flying into Raleigh together, they would be shooting a straight up visual approach. As coming around for final, the accident captain would call for gear down flaps 20 and would say to set speed at ref speed rather than 160 like other pilots. As the

gear would be coming down, the accident captain would call for flaps 40, but Capt. Willetts knew he could not give it to him because of the configuration warnings and the airplane needed to slow before he could give it to him. Capt. Willetts would have to tell him to bring the power up until they could get the appropriate time to set the flaps. There were mental lapses that took place about 5-8 years ago when the accident captain was an F/O. There were things he thought the accident captain needed to work on as an F/O. They thoroughly briefed those things and he would tell the accident captain that if he was going to do that, he needed to monitor the airplane and the airspeed and the attitude rather than looking outside. As time passed and when the accident captain became a captain, Capt. Willetts never saw anything to suggest that the accident captain needed more training or to suggest that he was not capable.

He thought seldom would two weak pilots or two great pilots be paired together. Usually one was weaker and one was better and they would outweigh each other. The accident F/O did not voice any concerns to him nor did he hear of any concerns that she said to other people. He did not hear anything from the accident captain either. If the accident F/O asked him about flying with the accident captain, Capt. Willetts would have told her that she was in "capable hands." He would tell her to do her job as trained and she would be fine.

The interview concluded at 1835.

7.0 Interview: Stanley Pearce, First Officer, UPS

Date: August 16, 2013
Location: via Teleconference
Time: 1915 CDT
Present were: David Lawrence – NTSB; Dr. Katherine A. Wilson-NTSB Normand A. Bissonnette – FAA; Larry Ashby – UPS; Drew Middleton – UPS

Mr. Pearce declined representation.

During the interview, Mr. Pearce stated the following:

His full name was Stanley Earl Pearce, Jr. At the time of the accident, he was employed by UPS as a F/O on the A-300. He estimated his total pilot time as 11,000-12,000 hours, with 4,000-5,000 hours flying the A-300. He stated that he had flown the A-300 for 8 years.

He stated that he last saw the accident F/O approximately 1.5 hours prior to show time (at about 0115-0120L) at the Louisville (SDF) UPS operations (OPS). They had never really met before but he had seen her before. She was doing the pre-departure paperwork. She came over and they chatted for about 15-30 minutes about usual pilot stuff. He left the crew room about 0150. She seemed gregarious, very happy, upbeat, and engaging…a normal state of mind.

He did not see her resting at any time, and knew she had come in from Rockford, not sure if she rested.

He did not recall anyone saying anything good or bad about her "…nothing like that…" and that she had no concerns about flying from SDF to Birmingham (BHM). He had heard nothing about her except she was a fun person to be around, "just gregarious." "She spoke about trips in general…usual pilot banter…."

He did not hear her talk about her weekend layover. He overheard "…maybe a little of her friends in the pool…having a good time…."

She did not look anything out of the ordinary…usual night cargo look…no obvious fatigue signs.

He had not seen the accident captain in SDF the morning of the accident but did see him the previous morning when the accident captain rode jumpseat on his flight.

He stated that the accident captain was professional, well dressed, extremely fit, a gentleman, and courteous. He showed no signs of stress or fatigue.

He had known the accident captain for 13 years, and that they had flown together on the DC-8 about 11 years ago when he was a FE and the accident captain was an F/O. He recalled the flight as "professional".

When he last saw the accident captain, he looked like the same guy as always; reserved, family man, perfectly fine with no concerns about flying SDF-BMH. He did not see him yawning. He had not heard anything bad said about the accident captain. F/O Trammel's experience with the accident captain was that he was a cautious man with the same demeanor inside and outside of the cockpit.

He stated that they were crewed together on the DC-8 in 2003, and that that was the last time we flew together. He had not witnessed the accident captain flying as PIC when F/O Trammel was on the jumpseat.

He had flown into BHM many times and he had landed on runway 18.

He remembered it as an RNAV approach, the shorter of the two runways, and that you would prefer to land on (runway) 6/24 because it was longer, had an ILS, and had a shorter taxi to the ramp.

The only time he landed on 18 was due to weather when it prohibited them from landing on 6/24.

He stated that there was high terrain in many quadrants of the airport, north of the airport and south. It was an airport that you had to be very cautious about high terrain.

He stated that he had been "green lasered" previously on an approach to runway 24, and that he debriefed the incident with the FBI.

When he heard that the accident crew was landing on 18 he was wondering if it was a weather issue or runway closure issue as typically he would not be landing on 18 unless operationally necessitated.

When he flew with the accident captain, he did not recall a time when the accident captain was an F/O that he had ever told another crewmember to go around or point out any approach deviations other than normal pilot stuff. He witnessed the accident captain doing things per SOP.

He believed when he flew the approach to runway 18 that it was an RNAV approach at night approximately two years ago. He stated that he and the other pilot discussed the taxi procedures in depth as it was not a normal taxi to the ramp.

It was a standard non-precision approach, and he did not recall any particulars about the approach other than it was mostly VMC with some thunderstorms in the area. He stated that it was more of a visual approach than one to minimums.

There were many issues with Atlanta ATC. They "tend to hang you up high" when arriving into BHM from the north, and that you had to scramble to get down. When he had landed on 18, he had come from the south. If there was a late runway switch, the crew could be pressed for time coming in from the north.

Landing on 18 was not as bad as he thought and they had no EGPWS issues.

They had no non-normal auto callouts, and sometimes the A-300 has callout anomalies.

He was the PF on the 18 approach, and that they had no issues with seeing the runway environment or the PAPI, but did not recall when they saw it. They had no approach deviations. He did not recall the approach being any different than another non-precision approach.

He further stated VNAV approaches on the A300 could be difficult, you cannot be high during set up and when the autopilot turns off in gusty winds you need to turn the command bars off to make sure you are not getting bad information.

He had no questions for the interviewees.

The interview concluded at 1951L.

8.0 Interviewee: Michael Alan Trammel, A300 First Officer, UPS

Date: August 17, 2013
Location: via teleconference
Time: 1208 Local
Present were: David Lawrence, NTSB; Katherine Wilson, NTSB; Normand Bissonnette, FAA; William Middleton, IPA; Lawrence Ashby, UPS

Mr. Trammel declined representation.

During the interview, Mr. Trammel stated the following:

He was 48 years old. He was a first officer on the A300 at UPS. He had been with UPS about 16 years and flew on the A300 about 11 years. He had about 10,000 hours total time and about 5,500 hours on the A300. He had no PIC time on the Airbus but was close to being able to transition to the left seat.

He had "extensive" experience operating into Birmingham Shuttlesworth Airport on the A300. Birmingham was his home so he would jumpseat in and out to go to work. He also operated the flight into Birmingham quite often. He was scheduled to fly the same leg as the accident flight on the opposing day the same week. He had traded trips with the accident F/O for the Friday after the accident occurred and had the accident not have happened he would have flown back into Birmingham with the accident captain.

The approach to the airport from the north appeared to be constrained due to Atlanta and Birmingham airspaces overlapping that leave the aircraft high for an approach. The 10-10 page alluded to this. If a flight was not handed off efficiently, then a pilot could find himself close to the field. A crew might have to prompt Atlanta for the descent. Even if the handoff was efficient, by the time the flight would be in the Birmingham airspace the flight would be above the 3 to 1 descent path.

UPS flights usually went to runway 24, or runway 6 if the weather was low because it had CAT 2 capability; runways 18, 24, and 36 were restricted due to terrain. A pilot coming in to Birmingham would have to slow down in preparation for getting dumped into Birmingham. If flying to runway 6/24, a flight would have lateral distance to aid in its ability to get down. The lateral distance aided in getting the airplane down and configured. If coming in for runway 18, that runway was straight off the nose. There was no lateral distance to help get you down. The descent into Birmingham was fairly steep, especially into runways 18 and 24. The runway 18 approach chart did not allow a night approach. RNAV 18 and LOC 18 approaches were identical from the FAF inbound. The RNAV GPS to 18 was allowed but the localizer was not. An ATC rule made a change 6-8 months ago that states a flight cannot land in the opposite direction and this was abided by in Birmingham pretty strictly. If ATC was calling for runway 24, a flight could not land on runway 6 without certain circumstances. The flight had to land on the active runway. He thought in the case of the accident flight they might have gotten time compressed.

He knew both accident crewmembers. He had flown with the accident captain and knew the accident F/O a little bit. He was also an F/O so he would not have had a chance to fly with her. He reviewed the approach plates for runways 18 and 24.

On the night of the accident, he had departed Birmingham and was to fly to Peoria and Rockford. He departed Birmingham off runway 6. The PAPI was not working on 6/24 because of construction. A crew could do a RNAV GPS to 24 but from the DA down there was no viable vertical guidance. If a crew was familiar with Birmingham, they would know that terrain surrounds all runways except 6. The runway sits in a hole and it could not be seen until late in the approach. Runway 18 was more visible because it was a straight in. The RNAV GPS to 36

was not allowed at night. The localizer according to what he was reading had TERPS data for the localizer 18 and did not allow for a nighttime approach. There was daytime data for having DME at IMTOY. Next to the TERPS at night, it stated that it was not authorized. There was a note at the top of the approach that stated when the VGSI was inoperative the procedure was not authorized at night. He thought the note at the top was confusing because at the bottom it said it was not authorized anyway. He heard from the NTSB briefing that the accident crew briefed to runway 18 so if that was the case then what he had said was NA anyway.

This accident was personal to him because it was his airplane, his home.

From the final approach fix down for the localizer and RNAV the minimums were identical. The RNAV GPS to 18 was allowed, the localizer was not at night.

The Airbus had multiple places to read DME in the cockpit. If the accident crew were to read distance displayed on the ND (Distance to runway) as opposed to LOC DME from the PFD they would have started down early. If a pilot was not diligent and did not point to the DME they needed to read, it was easy to make a mistake. He said that mistake was common in the simulator. It takes away the peripheral vision of seeing the ground coming up at them.

There were no lights on the hillside whatsoever.

Knowing how crews read DME from different sources, it was possible and would be easy to do.

He did not remember in the NOTAMS if it addressed the PAPI to 18. He knew the PAPI to 24 was inoperative.

The weather when he left Birmingham that night was thunderstorms in the area south of Birmingham. It was pretty much a clear ride. He was surprised that the accident crew had any cloud deck to deal with because it was so clear when he had left. He had a push time of 2210 but they pushed at 2206, there was a 5 minute warm up so he thought they probably departed about 2215.

He was pretty sure he had flown a visual to 18 at night but was not sure if he had done an RNAV or instrument approach to it.

On the NAV display, they could draw it down and get the rough mileage to the runway. On the PROG page it would show a pilot the mileage to the runway.

Birmingham was a special airport in the sense that there were special pages in the Jeppesen. At one time, it was a specialty airport with pictures provided of the airport. It was commonly a problem for stabilized approach criteria. A pilot could see the terminal if he knew what to look at but he could not see the runway.

When he shot the visual to 18, he saw the PAPI.

The only safety information provided by UPS was located on the Jeppesen 10-10 page. UPS maintained a safety reporting system (Event Reports, ASAP) however he had not submitted any reports regarding his concerns at KBHM. FOQA information indicated unstabilized approaches and how ATC might keep a flight at high altitude. Runway 36 was not allowed at night. Pilots at times would get safety updates through the chief pilot or FOQA reports identifying airports like Birmingham where they have had concerns in the past.

Most of the time they flew the ILS. He thought about 20% of his flights resulted in a non-precision approach. Of those 20%, most were flown in PROFILE mode. Since they started flying the PROFILE approach he did not think he had ever done a vertical speed approach. PROFILE was typically what he did.

The approach he flew to 18 was stable with no EGPWS alerts. It was several years ago. He thought he and the captain he flew with were from Birmingham and they were very aware of where the terrain was. There was no warning in that manner. They were on the PAPI all the way down. He had not heard of others getting warnings flying to 18; it was so infrequent. He was not aware of many approaches to 18.

He had never known 6/24 to be closed in his experience. He knew they were doing work on the end of 24. There was not a time period when the airport was uncontrolled and 6/24 was the primary runway. It surprised him to hear that it was closed the morning of the accident.

He was not in a position seniority-wise to upgrade. He left the military with about 3300 hours total time. He was not sure of his PIC time but he spent the better part of 6 years flying as PIC.

He had told a pilot to go around. The only time that came to mind was flying into Birmingham. He could not recall another time. It was obvious to both he and the captain that the approach was not going to work or something was on the runway. They came to the decision to go around almost simultaneously.

When on approach to 18, he knew the flight was always going to get "slam dunked" coming from the north. He would have prepared to slow down. The runway would be seen from way out; it was crystal clear.

He had flown a few localizer approaches; they were very few of the 5% of non-precision approaches. He mostly flew RNAV approaches unless he had to do a VOR or localizer.

He had not personal knowledge of people making ASAP reports about Birmingham.

He had known the accident captain for 4 to 5 years and had flown with him a handful of times. They were not close friends, but would talk and shake hands. They had recently flown together and he had no concerns with the accident captain's capabilities. However, some pilots had indicated to him that the accident captain was one that you must watch closely. F/O Trammel never had any issues with the accident captain in the airplane. The accident captain always did things correctly and was diligent in studying. He had nothing to back up what he heard from other F/Os.

He last saw the accident captain the night of the accident or the previous night. He thought it was the night prior either in the cafeteria or the ready room. They spoke about how they were doing. The accident captain did not mention if he was sick and did not notice anything out of character.

He flew to Birmingham with the accident captain within the last month or two. They did not fly to 18. He thought the accident captain was the PF. There were no problems on the approach into there. There were no abnormals or emergencies.

He saw the accident F/O very briefly on Tuesday morning. He thanked her for training the trip with him on Friday. She seemed normal, happy and smiling like she always did. She never discussed any concerns she had about the airplane or working for UPS. He had only recently gotten to know her.

In his interactions with the accident captain, he did not express any concerns about flying the A300 or working for UPS. He thought the accident captain was happy to be working at UPS.

He never heard anything bad or good about the FO. He had heard from 2-3 different people that she was a good pilot.

His encounter with the accident crew most recent to the accident flight was brief.

The interview concluded at 1258.

9.0 Interviewee: Johnny Ray Gresham, A300 Captain, UPS

Date: 17 August, 2013
Location: Telephone Interview Sheraton Birmingham Hotel
Time: 1305 Local
Present were: David Lawrence, NTSB; Katherine Wilson, NTSB; Normand Bissonnette, FAA; William Middleton, IPA; Lawrence Ashby, UPS

Capt. Gresham was represented by his wife, Janet Gresham.

During the interview Capt. Gresham stated the following:

He was an A300 captain and had been flying since 1985. He had about 10,000 hours total time. He had been flying the A300 as Captain for 5 years.

He had flown with the accident F/O before, they crossed paths at work and had a decent work acquaintance. They would talk back and forth. He flew with the accident F/O on flight 784 for a weekend layover. They blocked out at 0857Z. He could not recall any abnormal events on this flight and he noted in his logbook that it was a "good leg." It was a good flight into San Antonio. He landed that leg and had been to San Antonio quite a bit. It was a nice clear night and he pointed out things like towers and obstacles; the accident F/O was responsive to his input. He was trying to make her situationally aware in case they had to go around, and he liked to make

pilots aware of where they were. He did not want to get distracted by the beauty of what was around them. The accident F/O was very responsive and followed SOPs.

When the crew arrived in San Antonio, the accident F/O was not going out to dinner with him because she was meeting a friend who worked at SWA who was working on the SWA FOM. They were going to discuss the UPS FOM and anything her friend might be able to pull out to help. There was a good chance that her and her friend talked about FOM operations so that may have been more in the forefront of her mind. They had a 60+ hour layover in San Antonio. The crew met on August 12th to operate flight 789 from San Antonio back to Louisville. The crew met at the normal show time for a 2253 local time departure but blocked out at 2251. San Antonio had taxiway closures. The accident F/O had the 10-9 page out and was really helpful to make sure of what places were closed. He was real familiar with San Antonio. The accident F/O was helpful in telling the captain about closures. While discussing issues with her, she seemed generally interested in listening and learning, stating she was "Real responsive, real situationally aware."

Capt. Gresham noted that both he and the accident F/O mentioned CRM, and discussed the stressors of flying between 2100 and 0900, noting the limits of not being able to have visual situation awareness, about not seeing everything. They also noted the stressors with your body flying on the back side of clock and that you can be tired, stressed. He stated that by virtue of the career, they had to face that and the accident F/O faced that in a positive way. The accident F/O spoke of feeling pressure of managing safety with the company's profitability. Capt. Gresham spoke of working for the company and that they had a profit margin to maintain but the pilots were flying an airplane and had safety to maintain. He also stated that pilots have to make judgment calls and he thought the accident F/O had equipped herself to make a good call if she could not fly.

He described the accident F/O as a "top notch person" and very approachable. They had flown 2-3 times together or 4-5 legs with no indication of non-procedural activities or anything less than what was set forth in the manuals. She was not a "cowboy pilot" but a very professional aviator.

He saw her as she was walking out the door and knew she and the accident captain were going into Birmingham. He knew Birmingham had some challenges and hoped the accident crew did not get met with one of those challenges. He stated that historically Birmingham had some challenges the way they brought a flight in and that a crew had to really pay attention.

The accident F/O said she was going to meet up with a friend and be back at the hotel on Sunday night. He was not sure if she returned Sunday night or Monday morning. However, at show time she was there and appeared to be rested and prepared for the flight. They got on a crew bus and went to ops and he remembered she mentioned she was going to Houston, which he said was about a 2.5 hour drive. He was not sure if she would jumpseat or if her friend would come and then they would drive there. When she got back on Monday, she told him she had gone to Houston. She said a couple days together, her friend just got new house. They sat by the pool and her friend worked in the training department at SWA, and they spent a lot of time discussing the UPS and SWA FOM.

Regarding her CRM skills, he thought if he did not remember anything then it was good. Her CRM was good. She would talk to the captain. She did not seem at all shy about communicating things. She seemed to always work together with the captain. She loved what she was doing and enjoyed it.

Safety was his priority and he did that through the use of good procedures. He would brief that if the F/O saw something to tell him and he would do the same; and the purpose in the cockpit was to trap any mistakes that start before they become errors and mitigate them before they become accidents.

He did not recall any specifics of the accident F/O not doing anything procedurally as PM. He could not recall if made the 1000 foot call. He did not remember her saying it but also did not remember her not saying it.

The accident F/O was PF on the flight to Louisville. She landed the airplane safely. He remembered thinking "oh wow she's configuring on time, early." The flight was well stabilized before 1000 feet. He thought that flight might have been the night they got an extra turn which brought them over the east side of town. She handled it fine. They got intercepted and configured. He thought they landed on runway 35L. He was scheduled to be off on reserve after that and she said she was flying Peoria-Rockford and was going to do her leg. He joked that he hoped they did not turn him out.

During the flight, they discussed the challenges about having to make that judgment call of UPS pushing and pilots making call of when we were pushed to limit of fatigue. She gave him every indication that she was equipped to make that call and get adequate rest.

She did not mention any concerns about her future legs and there was no indication of having any stress about flying the Peoria Rockford leg other than she was working and not at home. She only mentioned going to Birmingham which was Rockford-Peoria-Louisville-Birmingham route.

He thought Rockford had a pretty good layover hotel and a good place to get rest. Birmingham could be "kind of a tired leg." He knew going in to Birmingham you were going to be tired. A pilot would not be at the same rest level as when leaving Rockford to Peoria. Then the crew would sit for 3 hours on the ground in Louisville. They would have to take precautions and pay attention more when tired. He made sure he was cognizant of that. Birmingham was "one of those legs."

If a pilot called in for fatigue, sometimes they would feel the pressure and that would sit in their minds. Pilots had to make a judgment call between the profitability and push of a major company versus safe flying of an airplane. As a captain, that was a judgment call to make. He did not think that the accident F/O would have had a problem saying something if she was fatigued.

Atlanta (corporate headquarters) was interested in the bottom line. Sometimes when a person was not at the bottom line, that person can truly lose sight of what those working at the bottom line were doing. Most were very supportive of them. If a pilot called in fatigued, a scheduler

might say they had to do this or get this done. Higher ups in the company would push down to the absolute edge of safety. It was his call to say if he was on the edge. He had heard it a number times. He thought once a trip over the last 4-5 years, the company would push them and pilots would say one day an accident was going to happen. Pilots felt pressure that the company had to make a profit. He felt that it was very likely if procedures were not followed that fatigue was a factor.

He never heard anyone say anything negative about the accident F/O.

He had not been faced with a situation to go around with the accident F/O. He tried to make it clear when he flew, if they see something and did not like it to tell him. There was a no fault go around policy. They would talk about it and then come back and do it again. It was a point he pushed in his CRM to tell him. He did not think she would have a problem saying go around but they were not faced with it. If a captain did not make it clear to say something, he thought the accident F/O seemed like a "happy pleasing person." So she would think she wanted to please this person but how would she tell them to go around. If she was told it was ok, she would say that.

He had only seen the accident captain at work and in a jumpseat. He could not say anything about him because he did not know him. He did not see him the night of the accident flight. He never heard anything about him. He did not recall anything about him.

UPS had a no fault go around policy. He believed he could go around all night long and truly believed no one would fault him. He thought the company believed that it was a good thing that he had the smarts and judgment to not do something stupid.

He had called in fatigued, and thought over the course of his time flying, he had called in 3 times total. There were ramifications. The first time it was so blatantly obvious that he was tired; he had been bounced around a lot. The next time he was thoroughly questioned as to why he called in beyond what he had on his event report. He felt like the person who called him was directed to call him. He made another fatigue call in February 2012, and was deducted fit pay for it because the company said he was not fatigued. There was a grievance in process.

When he called in fatigued now, it was in the back of his mind what was going to be said to him. He thought when he called fatigued he was going to get questioned.

He did not recall filing a report about Birmingham. He had filed an ASAP report a while back but it was not about Birmingham.

He could not recall a time when flying in civil aviation that an F/O or FE had told him to go around.

Interview concluded at 1403 CDT.

10.0 Interviewee: Robert Scott Bergen, First Officer, UPS

Date: August 17, 2013
Location: via teleconference
Time: 1605 CDT
Present were: David Lawrence, NTSB; Katherine Wilson, NTSB; Norm Bissonnette, FAA; William Middleton, IPA; Lawrence Ashby, UPS

F/O Bergen declined representation.

During the interview, F/O Bergen stated the following:

He was a first officer on the A300. He had about 6,000 hours total time and 900-1000 hours on the A300.

He had recently flown with the accident captain. They flew a 6-7 day pairing together that was predominantly EWR and CLT and they flew 3-4 legs each night. They also went to DEN and SLC then returned through DEN to SDF. The accident captain flew the first leg and then they swapped PF/PM duties every other leg.

His impression was that the pairing was uneventful. From his recollection they went into larger or medium airports except for one smaller airport in BDL. There was no unusual weather and it was a relatively routine trip.

His impression was that the accident captain was a very standard, competent, proficient pilot. He did the checklists. He was always ahead of the aircraft from start to finish with the flight.

They did not discuss any concerns about flying the Airbus but the accident captain did mention how the flight schedules had greatly deteriorated and had become much more difficult to fly and were more demanding. It was especially difficult when they rotated back to SLC; they got back to SLC in the middle of the morning. He believed their trip pairing started about 3 weeks ago and it started on a Monday night or Tuesday morning. The accident captain did not mention that he could not call in if he was fatigued but said the first couple of days of a trip were tough getting back into the schedule and the end of the trip as well.

He said that he had no concerns about flying with the accident captain. He was very standard. They had no abnormals or emergencies during their pairing. Everything operated normally.

He said it was the first and only time that he flew with him. He had never heard anything negative about his flying.

The accident captain seemed open to input from him. He would be very comfortable telling the accident captain to do a go around; that would not be a problem. He would always call for a go around even if the accident captain did make him uncomfortable.

The accident captain did not mention being sick. All the conversations about his family were very positive.

He knew the accident F/O personally. They went through A300 training together but were not paired in the simulator together. Everything he heard about her was she was professional and competent in the airplane as well. He saw her when she was flying with the accident captain in Ops and they had a brief conversation.

She had never mentioned any concerns to him and had never heard anything negative about flying with her. His roommate was her simulator partner in training and he spoke highly of her.

The briefings conducted by the accident captain were very thorough and never rushed. The accident captain was very competent and professional. His flying skills were normal. During the time they flew together they never flew any non-precision approaches. They did visuals backed up by the ILS.

He had personally flown into Birmingham. In his past experience they generally used runway 6/24. He understood that there had been some closures of runway 6/24 but he had not been to BHM recently. He had never landed on runway 18.

With regard to the accident captain's CRM skills, they were "adequate to good." He never had any negative experience with it. It was fine. He did not recall having to prompt the captain for anything during the trip like a checklist.

He was comfortable with the UPS fatigue policy but had not had to utilize it so he could not speak to it.

He was comfortable with the UPS no fault go around policy. He had used it before.

The accident captain was average in use of the autopilot. The accident captain used the autopilot about as much as other captains he had flown with. He would hand fly it up to 10,000 feet and turn it off at the final approach fix. Most of the landings they did together were visual.

The accident captain was above average with the FMC as well as the MCP.

In the time they flew together they never performed a go around. In his time flying, but not at UPS, he had recommended a go around to other crewmembers he had flown with because of an unstabilized approach. He had also called for a go around when in a jumpseat. He had been told to go around before when he did not stay ahead of a descent profile.

He stated he once called in fatigued at another airline (not UPS) and it was not handled well. He was called into the chief pilot's office. He called in fatigued after doing all night calls. After a trip he was requested to fly 2 additional legs for a total of 5 legs on that day.

He did not see the accident captain struggle to use the MCP or FMS.

While employed at UPS he had never felt the need to call in fatigued but he would if he needed to.

He had not heard anything negative about the accident captain as far as his flying went.

He reiterated that the accident captain mentioned several times during their pairing that the schedule was changing and degrading recently and it was hard to manage.

The interview concluded at 1636.

11.0 Interviewee: Samantha Amanda Minzer, UPS Rockford Ramp Supervisor

Date: 17 August, 2013
Location: Via phone
Time: 2350 CDT
Present were: David Lawrence, National Transportation Safety Board (NTSB); Katherine Wilson, (NTSB)

She declined representation.

She was a part time supervisor on the ramp, based in Rockford for 4 years. Her interaction with the crew was she said hi to them going up the stairs. She loaded the aircraft. She next saw them when taking the hazmat paperwork to the cockpit. They were early, not rushed, and she presented the w/b information and made some small talk. The crew read back the numbers for takeoff. She gave them the paperwork and "was out the door."

They did not mention any concerns about the flight. Their mood was not overly happy but happy. The total time of their meeting was about 4 minutes. She said both pilots came through Rockford together before. On those previous occasions, they never mentioned any concerns about their trip our route. She had never heard any other pilots make any comments about these pilots.

She had nothing more to offer.

The interview concluded at 0000 CDT.

12.0 Interviewee: Brad Leach, UPS Peoria Ramp Specialist

Date: 18 August, 2013
Location: Via phone
Time: 0000 CDT
Present were: David Lawrence, National Transportation Safety Board (NTSB); Katherine Wilson, (NTSB)
Representative: Denny Morris, supervisor

His name was Bradley James Leach, and he was a ramp specialist for UPS in Peoria since 2006. Asked about his interactions with the flight crew, he said the aircraft originated in Rockford, and stopped for about 50 minutes. He greeted the crew and got fuel information. He said hi to the crew, then went down to load the aircraft. When they left, he took the manifest to the crew, and did not really chit chat with them.

He said nothing was unusual, and it was a normal flight. They did not mention any concerns. Their mood seemed friendly. They did not seem tired. His total interaction time was about a minute when they arrived, and 1-2 minutes when they left.

There was one other person on the headset, named Robert Jansen, who was the part time supervisor. He had seen both crew members before, and wasn't sure if it was together. They had never voiced any concerns.

He had nothing further to add.

Interview concluded at 0013 CDT.

13.0 Interviewee: Nicholas Williams, UPS Van Driver

Date: 17 August, 2013
Location: Via phone
Time: 0015 CDT
Present were: David Lawrence, National Transportation Safety Board (NTSB); Katherine Wilson, (NTSB)
Representative: Mike Thomas - UPS airline safety investigator

His name was Nicholas Dwayne Williams, Sr. He drove the crew vans and also worked in flight control administration at UPS. He had been in crew vans for the past 2 months, and flight crew administration for 9 months at UPS.

He remembered picking the crew up at spot 9 when they arrived. They spoke about what time to meet up and fly back out. He dropped them off, and when it was time to go back out for the next flight, he drove them back out. It was rare for the same driver to pick up and drop off. From the back door to the ramp, it took about 2 minutes to drive.

He did not remember hearing the crew say anything about their sleep or rest, just how they would meet.

He remembered seeing the crew before individually, but this was the first time he remembered seeing them as a crew. He did not remember ever hearing them talk about issues flying the Airbus or their routing. He did not remember the exact time he picked them up. He remembered logging the pick up and drop off time.

He never heard anyone speak good or bad about either pilot. He characterized their mood as normal. Nothing was out of the ordinary.

Times, flight numbers, ramp spots and aircraft tail numbers are included in the log, and they retain those logs.

Interview concluded at 0027 CDT.

14.0 Interviewee: Patricia Hamilton, UPS Flight Administration

Date: 17 August, 2013
Location: Via phone
Time: 0029 CDT
Present were: David Lawrence, National Transportation Safety Board (NTSB); Katherine Wilson, (NTSB)
Representative: Mike Thomas - UPS airline safety investigator

Her name was Patricia Hamilton, and her title was flight administration for UPS for the last year and a half. Her job was to service the crew members for sleep rooms, jumpseat pass, logs, whatever they need.

She handled the sleep rooms with Mr. Beal, who had a child away in college, and she also saw the FO. The accident captain always had a smile. Her desk was right next to the ready room. She said that once they got the keys from her, they were on their own for when they went in the room. She logged when the key was checked out, but did not log when it was returned.

The FO seemed perfectly fine for someone who had just flown in. She wanted a sleep room. She did not remember seeing her go to the room, and the next time she saw her was when she was doing her preflight paperwork, and that was about 0315. She did not see her yawning or act any way concerning. she said she had met her before, and had never mentioned any concerns about UPS, the airplane, or the routes she was on.

Captain Beal always had a smile on his face and was upbeat. He received his key, and stopped to talk to several other pilots. When he left, he stopped by her and asked when she was going to bring her any more brownies. She never heard him voice any concerns about the company or airplane. She did not see him yawning. She also saw him when she was leaving at about 0315.

Keys to the sleep rooms were like the hotel card keys. There are boxes out the back in the stairwell and hallway where the crews throw the cards away. Sleep rooms were cleaned around 5am in the morning. She was not sure if the rooms had been documented following the accident.

Interview concluded at 0042 CDT.

15.0 Interviewee: Zachary Coleman, UPS Load Supervisor

Date: 17 August, 2013
Location: Via phone
Time: 0043 CDT

Present were: David Lawrence, National Transportation Safety Board (NTSB); Katherine Wilson, (NTSB)
Representative: Mike Thomas - UPS airline safety investigator

His name was Zachary Coleman, and he was a load supervisor for UPS in SDF for about 3 years. His interaction with the flight crew was when he met the crew at the airplane. He talked with the crew "a little bit." The FO was already settled in her seat, and was working on the radios. He unloaded the flight 15 minutes early. He gave them the paperwork and hung around for a short time. He went up to the cockpit about 0443. He was in the cockpit for 2-3 minutes at most. He said the captain walked out behind him after he arrived at the cockpit. His mood seemed fine. He did not see either pilot yawning, and they did not seemed to be tired. The captain seemed to be in a good mood. The FO did not say much. Neither mentioned any concerns about the load. He did not recognize the captain, but did recognize the FO. She had never expressed any concerns to him. He said he had heard that the FO was a really nice lady, and never heard anything bad about her.

He said he logged the load complete times. When he signed the paperwork he handed it to the crew. There was also a time on the paperwork. The load plan included the weight and balance. The load planner would load the airplane. He said the Airbus was one of the easier airplanes to load. Everything was normal. There was hazmat loaded onboard, but nothing special.

Interview concluded at 0053 CDT.