

**Factual Report – Attachment 1**  
**Interview Summaries**

**OPERATIONAL FACTORS**

DCA17FA076

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### 1.0 Interview: Mark Radloff, Ameristar MD83 Pilot

**Date: March 10, 2017**

**Location: Sheraton, Detroit Metro Airport**

**Time: 1500 EST**

Present: David Lawrence - National Transportation Safety Board (NTSB); Richard Neibert - Federal Aviation Administration (FAA); H. K. "Chip" Sieglinger – Boeing (via phone).

Representative: Robert Porter, Ameristar Pilot

During the interview, Captain Radloff stated the following:

His name was Mark Donald Radloff, he was 54 years old, and currently was a DC9 captain. He was hired at Ameristar on January 25, 2016, and had also flown for the company as a DC9 First Officer (FO) and captain, and an MD80 FO. The company had 2 MD80's, 4 DC9's, 2 Boeing 737's. They had 3 MD80 pilots, and about 16 DC9 pilots. The company currently had 2 MD80 pilots in ground school.

He had just checked out as a line and simulator check airman in January on the DC9, and was an MD80 check airman in the simulator. He was currently being trained to be a captain on the MD80.

There was no one on the jumpseat of the accident flight.

He had flown with the chief pilot previously. On the MD80, they had striated flying together in October 2016. He estimated he had about 15,750 total hours, with about 9,000 hours on the DC9 type aircraft. At Ameristar, he estimated he had about 90 hours pilot in command time

He was given drug and alcohol screening after the accident. He had never previously failed any drug or alcohol screening, and he had never been treated for drug or alcohol abuse. He had never been fired, terminated or asked to resign from any employment. He had failed previously failed his Saab 340 upgrade with Mesaba in 1996, at FlightSafety at LGA.

Ameristar MD83 pilots received their ground school training in Addison, Texas, and their simulator training at the American Airlines training center in Dallas, Texas. Ameristar used their own instructors to conduct their training.

His aviation background was all civilian flying. He started at the University of North Dakota (UND) as a student pilot, was an instructor there and in Wisconsin, and flew for Mesaba Airlines in turbo-props. He also flew for Midwest Airlines, Evergreen where he flew 747's, then flew ICE flights for Ryan Air before starting with Ameristar.

He said the charter was for the University of Michigan men's basketball team. He left the hotel at about 1130 local on the morning of the accident. The airplane was located on the west ramp at YIP, and they repositioned the airplane to the east ramp at 1230 for a 1430 local departure to IAD. The boarding and loading was all normal.

It was a "extremely" windy day. The wind speed did not concern him as much as the crosswinds. They decided to add some speed to  $V_r$  for an increased the rotation speed. He thought the speeds were 139/145/150 for  $V_1/V_r/V_2$ , so they went with the 150 speed for rotation. There were sporadic power outages at the airport, there was no ATIS, but ground control was operating. They got a barometric of 29.81. They were told the wind instruments had been blown down, and the most recent they had was about 1130 that morning which was 2-3 hours old, and showed sustained winds 260 at 35 knots gusting to 50 knots.

Taxi out was normal, and they called for the checklist, and did all the responses. On the taxi checklist, they re-checked all of their V-speeds and increased  $V_r$ , and Andreas said "don't rotate until I call for rotate,". All their conversation was pertinent information during the taxi. The used taxiway E1 to hold short of runway 27. Andreas coordinated with the Flight Service Station (FSS) to get their clearance since the airport was an uncontrolled with the tower closed. The then taxied toward runway 23L. They both looked at wind sock, and the direction was between favoring 23L and 27, and he said he was more comfortable with 23L since they had typically used that runway for departure. He said they were aware of a Baron that reported downwind to runway 27.

They taxied onto runway 23L, held the brakes, all SOPs completed, advanced the thrust levers initially to 1.4 EPR, released the brakes and engaged the auto throttles, and then applied full takeoff thrust with  $N_1$ 's checked. He heard Andreas call the "clamp" annunciation on the FMA, and was then focused on the rudders to maintain the centerline during the takeoff. There was about a 20 degrees crosswind from the right. Andreas called airspeed alive at 80 knots, he saw 80 knots, and said "checks", and then focused his attention down the centerline. Andreas then called  $V_1$ , then rotate.

He rolled out aileron input he had for the crosswind and started back pressure with the yolk. The problem began there, and he had a normal rotation rate and he got to the point where he should have noticed the nose coming up. He had about 4,000 hours on the DC9 types and knew exactly when the nose wheel should have come off the ground, but on this flight it did not happen.

He began adding more back pressure as he was sitting forward in the seat, brought the yoke back even further, which was now more than half past his thighs, but did not pull all the way to the stops, but further back than for a normal rotation, and the nose was still not coming off. The yolk was felt heavy, like there was a stack of bricks on the nose of the airplane since it wasn't coming off the ground.

He told Andreas "this thing is not flying," and then said "abort/abort/abort". He saw a chain-link fence ahead of them, and knew they weren't going to clear that fence even if the airplane did get airborne. When he aborted, he didn't even feel the nose wheel come down, even if it ever raised off the ground.

He brought the throttles to idle, initiated reverse, got onto the brakes, and then got the spoiler handle deployed. Andreas was on the brakes as well. He didn't think they exited the runway at that high of speed. It appeared they missed most of the approach lights for 5R, and they kept sliding. They had a big "kathump" when they hit the ditch and then stopped.

He knew what had happened, and tried to get his head around what happened. Andreas told him "you're not supposed to abort above V1" and he replied "I know, but I had nothing, I had absolutely nothing" to rotate the airplane. Andreas initiated the evacuation checklist, and he grabbed the checklist to back him up. He pulled the fire handles, and Andreas pulled the CVR circuit breaker.

Even though he should have called for the initiation of the evacuation, Andreas called for it. He said they lowered the flaps to 28 degrees and shutdown the engines. He commended the flight attendants because, while the cockpit door was closed, he heard the "heads down stay down" calls from the back. He saw everyone running from the aircraft out the corner of his eye, and he said he was the last one off the airplane.

The passengers were milling around in the field, and their reps were mingling with group, then fire trucks and police arrived. The UM folks called for buses, but most walked to closest building. The wind was just "howling" and it was bitter cold. There was no sign of fire, and he did not feel unsafe hanging around the aircraft. They used an ambulance for shelter to help get out of the elements.

When asked what the official weather was for departure, he said they did not have specific weather, and that all frequencies from tower were down, and Pat got them an RTAM temperature, and they used that for our speeds and performance calculations. The ATIS was out, but they had a barometer. There was no wind or weather information for the airport, although they had wind information in their paperwork, but it was about 3 hours old. They were not aware that the control tower had been evacuated.

He said the speed of the wind was not his main concern, but the direction for the crosswind. When asked how they would have calculated a crosswind component for the takeoff, he said they could only estimate the wind speed. When asked if there was any source of weather information provided at YIP at the time of departure, he said "no."

He said he was not sure if their ops specs permitted departures at airports without weather reports. He did not recall if Andreas called DTW for weather. They were approved for departures from an uncontrolled airport. They were never aware of the tower being evacuated, and ground control told them there was a power outage.

When asked if he had any concerns about departing knowing the tower was closed, the power was out, and they had strong winds with no weather reports, he said “no”. It was VFR, clear, and they had the wind for wind guidance, the barometer, and temperature from RTAM.

He and Andreas had not briefed anything special about rejects prior to their trips since he was going through training. It was understood that the pilot in the left seat would always be the one to initiate a reject.

The main reason for the abort was because the nose was not coming up when and where it should have. He was experienced on the MD80, having flown it at Midwest Airlines, and he had never pulled so far back on the yolk during rotation and the nose not come off the ground.

He did not see the airspeed indicator to note the airspeed as they left the runway. It was the pilot monitoring’s job to note the speed of the reject for the brake cooling charts later. He thought he rejected about 150 knots since that was the rotation speed they had briefed earlier. He heard the “airspeed alive, 80 knots [checked], V1, rotate” calls, but could not remember if he heard the “V2” call out since they never got airborne.

They do have low/high speed regimes on takeoff. Below 80 knots you can abort for anything, 80 knots to V1 there are narrower reasons like engine fire, failure, or a third one he could not remember at the moment. When asked if there were any criteria for rejecting above V1, he said there was, but he would have to look that up. He did say they received training on rejected takeoffs in the simulator, and he had not rejected on the line.

He did not observe the actual evacuation since they were doing the checklist, and when they were done the back end of the airplane was empty. He was surprised that many people were off the airplane that quickly. He confirmed that Andreas called for the checklist, and was the first one out of the cockpit.

Andreas did the evacuation checklist from memory, and he followed it up with the checklist. They trained for evacuations in the simulator, and the scenario was typically the same each time. The essential steps they ran through were essentially the same they trained on. The typical simulator training was for a single engine landing with an engine fire after landing forcing an evacuation.

He read though pilot manual guidance that said rejected takeoffs above 100 knots only for safety of flight items. When asked if there was specific guidance on what to reject for above V1, he said there was not any.

He said his health was good. He held a first class medical with a limit to have corrective lens, and he had them on the accident flight. He took medication for hyper tension. He had not had

any changes in his health or financial state, said he had a great marriage, and there had been no changes in his personal life in the last year.

There were no concerns about the weight and balance. They did not breakdown children weights, and did not use half-weights. He talked to ground loader, and wanted them to start loading in the aft of the D bin first, then load forward. They loaded the crew bags in C1. There were a few corrections on the load form, and those were his mistakes. He had filled those areas out ahead of time, and after the loading, he made the corrections.

They had flown sports teams before, and always used the standard passenger weights, and didn't have them weighed individually. He did not know if they had a process to partially weigh some passengers and use assumed weights for others. No one flagged the type of load this was, they considered it standard. They do have the provision that larger baggage would be weighed. Andreas actually did the bag calculations that were entered on the form.

The max takeoff weight was from the performance analysis for YIP and the runway they would use. The Ameri-balance program determined the cg, that would then be entered in the takeoff condition computer (thumbwheel). The takeoff limitation was temperature limited, and Andreas got that via the RTAM.

They did not use an assumed temperature for the takeoff, it was a max takeoff. There was no weight and balance display or pictorial provided to them, just the numbers.

The PM follows up with setting the takeoff thrust.

He described yoke as very heavy, and the feedback was based on the weight of the controls.

He didn't know if they were using balanced field calculations for takeoff, and thought that was calculated by the flight followers.

He felt the wind direction had an influence on the takeoff roll, not necessarily the velocity. He said he was dead on the centerline during the takeoff.

When asked if there was a flight control check prior to the takeoff, he said he could not remember if Andreas completed that check.

He believed he had a minimum of ten hours to check out as captain, and would have gotten about 5 more legs going forward. Andreas always did the weight and balance, and he hadn't had the opportunity to do one yet, but he was confident he could do it based on his experience on the DC9 and its program.

He commuted to YIP Friday evening from Milwaukee, then flew to LNK, Saturday evening for a layover, returned Sunday, and sat for 2 days before this departure. The airplane had sat Monday and Tuesday. There were no maintenance checks done, but there was an auto throttle write-up and a navigational display issue on the captain's side when they returned from LNK, and were fixed by their own Ameristar mechanics.

The MD80 had viscous dampers but no gust lock. The airplane had been parked facing to the north, and the thrust reversers had been deployed to prevent any wind or debris going up the tailpipe. That's not typical. There were no covers on the inlets. The APU had already been started when they arrived.

There is no flight control check prior to engine start. After engine start, typically the FO turns off aux pump and transfer pump and moves the wheel left and right, looking for a spoiler light and movement on pressure gauges. On taxi out, for the flight control check, the captain holds tiller for left/right rudder movement. The FO does an elevator augmentation check, pushing full forward on the yolk and looking for a blue elevator augmentation light. While full forward, the wheel is turned to the left then the right. He was not sure if Andreas had physically done the flight control check, but Andreas told him he did do the check as part of his normal personal flow.

Ameristar does not have an ASAP program. Safety issues are encouraged to be brought directly to the Director of Safety. He did not know if they had a de-identified reporting system.

He had no concerns flying for the company. He felt he was properly trained for this event, though he accidentally hit the reverse thrust first before deploying the spoilers. He felt the procedures they had were sufficient to address the event.

He concluded by saying that he felt the takeoff rotation just didn't feel right, and he was confident of his decision to reject the takeoff.

Interview concluded at 1625.

## **2.0 Interview: Andreas Gruseus, Ameristar MD83 Chief Pilot**

**Date: March 11, 2017**

**Location: Sheraton, Detroit Metro Airport**

**Time: 0900 EST**

Present: David Lawrence - National Transportation Safety Board (NTSB); Richard Neibert - Federal Aviation Administration (FAA); H. K. "Chip" Sieglinger – Boeing (via phone).

Representative: Talbot Martin, Attorney - Barnett and Borth, LLC

During the interview, Captain Gruseus stated the following:

His name was Andreas Conny Gruseus, and he was 41 years. His current title was Ameristar chief pilot for all their Part 121 operations, and he was a check airman on the MD80. He joined Ameristar in 2004. He had previously held the positions of line captain on the DC9, B737 and MD80, and he was current on all three airplanes, alternating 6 month checks to maintain currency.

Ameristar trained their DC9 crews in Wilmington, Ohio (Airborne Express), the MD80 crews at American Airlines in Dallas, Texas, and the B737 crews at Pan Am in Miami, Florida. Ameristar

uses their own instructors for training. He held type rating on the B737, DC9, Lear jet, and Falcon. He held a first class medical certificate with no limitations.

He had been flying with Mark since November 2016, and he was doing Mark's difference training on the MD80. They last flew together on Sunday from LNK to YIP, spent several days in a hotel, and next flew again on the accident trip. The airplane did not fly during their down time in YIP until the accident flight.

He estimated his total flight time at 9,700 to 9,800 hours, with several thousand hours on the DC9 type. He had about 700 hours total time on the MD80.

He was given drug and alcohol screening after the accident, and had never previously failed a drug test or been treated for drug abuse. He had never been fired or terminated from any employment. His only check ride failure was for his commercial single engine certificate. His last proficiency check was in January 2017.

They left the hotel at about 1130, with a 1230 show time. The airplane was parked facing north at the Avflight west ramp. At about 1145 the flight attendants showed up. Mark went to the airplane first to begin the preflight. He remembered Mark asking why reverser buckets were deployed, and that was a normal procedure with high winds. He went back out to the airplane, and was not sure if the APU was running at the time. He printed the flight paperwork, including the risk assessment form, called to dispatch, and told them they would reposition to east side to load passengers. Their dispatch then called him and advised that there were issues filing the flight plan, and so they brought paperwork over to east side after the airplane got repositioned.

As he walked to the airplane, Mark did the preflight, they both did their cockpit checks, and then waited for supplies to be loaded. At about 1240pm, they did their repositioning checklists, started the airplane, but couldn't get a hold of ground control. He called the tower via his cell phone, and they said they lost power and airport was uncontrolled. They then repositioned to east side, facing south

One of the busses were waiting when they got to the east side, and the cheerleaders and band members were there. After they parked, he went in to make sure the passenger screening company was there. He got to the front desk, and there was no power to print the paperwork, so they emailed it them and maintenance printed it up and brought it over. Mark then briefed the loading process in the Passenger Handling Manual. They talked about loading, and Mark took care of all that. Once he got the flight plan, the cockpit was set up with the Jepp flight plan they were given had an estimated takeoff weight of 146,000 for the takeoff weight to program the FMS until they got their final numbers, and they wrote down those speeds. The winds were pretty gusty, and they looked at their last known temperature, looked at runway 23R, and decided on an increased rotation speed to that for their maximum weights of 156-157,000 pounds.

The team showed up, and once all the passengers were loaded, he went downstairs to the aft cargo area, which was already loaded. The mid cargo bin was close to being full, and he noticed a couple of blue bins. They weighed those and kept those in the mid compartment. Once



loaded, they gave them the baggage counts, finished the load manifest, and the release was signed and emailed to director of operations and director of safety.

Before the cockpit setup was complete, they actually did the takeoff briefing for the pilot flying (PF), which included normal, standard, emergency procedures. The only extra comment he had for Mark was if anything happened in the air on takeoff, they were not coming back to YIP but instead going to DTW. They did the before start to the line checklist prior the passenger loading, and below the line after they were loaded.

They set the final numbers, got their takeoff numbers, and used 146,000 speed with an increased rotation speed of about 5 knots for a weight for the maximum 156,000 or 157,000 pounds allowable takeoff weight. They completed the before start checklist below the line, and were ready for engine start. They used the CTAF (common traffic advisory frequency) to announce their taxi out. We discussed the wind sock, and either runways 27 or 23L. The winds were more in favor of 23L.

Once holding short of runway 27, he called ATC on his cell phone to get a clearance. He then had to call DTW approach and was told they didn't have a flight plan on file, so he called the FSS to file. They waited a bit, then called DTW approach and got their clearance with a void time. Mark advised passengers on PA of the short delay. The only thing they had to change in the flight plan was to use the AKR5 departure SID (standard instrument departure). They set their radios and radials. He got on the CTAF for communications, and did the appropriate checklists, and taxied into position. Mark was the PF in left seat.

They set normal max thrust for takeoff, takeoff was selected on the TRI panel, flight directors were both in view, and TO/TO/Altitude (3,000 feet) were armed on the FMA. They were aligned with runway and agreed with their heading. The thrust was initially set to about 1.4 EPR, and the auto throttles were then on. He made sure the thrust was set as indicated on EPR panel and per the reference bugs. The thrust came up and they had the EPR to annunciation. SOPs for calls included: clamp, airspeed alive, 80 knots – Mark called crosscheck, V1 then rotate. When he called V1 Mark removed his hands from the throttles. He then called rotation, and then heard Mark say “I can't get it off”. Once he started to reach for the yolk, the throttles were disconnected and then at idle, and at that point “I was along for the ride and on the brakes.”

He remembered during the abort he was stepping on the brakes very hard and assisting, and he adjusted the thrust levers to max reverse thrust. He thought he may have said something like “no, no” but it was already too late.

The airplane “veered” slightly to the left toward the end of the runway. He did not recall the speed they exited the runway, but thought it might have been less than 60 knots with the thrust reversers fully deployed. Both of them were on the brakes. He remembered hitting the fence, and then the airplane came to a stop. He got on the PA and announced “evacuate” three times, and then heard the flight attendants make their announcements.

He got on his cell phone and called DTW approach and told them they needed crash fire rescue, and then they did the evacuation checklist

When that was done, he opened the cockpit door, and Mark exited through the 1L door, and he walked to back of airplane, then back to the front to make sure everyone was off the airplane, and exited got out the slide on the 1L door.

He found a representative from the team, and asked for a head count of passengers. He was told everyone was there with no injuries. Fire and rescue crews were there “very fast.” The FAA then showed up shortly after, about 30 minutes after airplane came to a stop. He remembered it was cold and windy when they were outside the airplane.

The last weather for the airport was for 1153 local time. The ATIS was out of service since they lost power. He used his cell phone to call the ATIS frequency, and got the 1253 weather that was just an updated version of the previous weather with winds about 260 at 40 knots. He then used his cell phone to check weather at DTW and got the 1353 weather at DTW. They started taxiing out at 1420 or 1425. The airport was VFR.

For the winds, they used the last reported on the 1153 METAR, and he called Pat and got the RTAM temperature. This process addressed in their GOM. They did not calculate a crosswind component for runway 23L. They used 23L based on the wind sock.

They did not have any official weather from YIP when they departed. When asked if he wanted a wind check for departure, would that be available, he said they could check the wind sock for direction, and a windsock inflates fully at 15 knots. Their Opspecs have authority for operations at uncontrolled airports. He said the Opspecs said you would have to have an ASOS, AWOS or an official observer. They did not have those.

Their policy was not to use flex or assumed temperatures for takeoffs. Their maximum takeoff weight was landing weight limited.

They did not know that tower had been evacuated, and someone answered the phone and advised that the airport was uncontrolled. He did not have any concerns about this departure. They were within CG, they were thousands of pounds under the max gross takeoff weight with plenty of performance. He said “there was no reason for the airplane not to fly.”

For the passenger weights, they always use the standard weights and do not use half weights for children. Even if it’s a sports team, they always use the standard assume weights. For baggage weights, all bags are 30 pounds unless they are heavy, and then they are counted as double bags for 60 pounds.

For the flight control during the taxi out, the pilot monitoring (PM) would conduct that. He did the flight control check on the taxi. When he moved yolk forward, he looked for the blue elevator power light to ensure they had additional pressure for stall recovery. This was the elevator augmentation. The control tabs should be the only thing moving when you move the yolk forward. He did not recall feeling anything different on the check. He also brought the yolk back. He did not recall ever feeling anything unusual during a flight control check.

The rotation speed was increased by about 5 knots. At the Vr call, he did not recall seeing the yolk come back since he was focused on the airspeed and instruments. He did not recall it coming back further than normal. Mark said something about not getting it off the ground shortly after the rotation call. He never felt the nose come off the ground, but everything happened so fast. By the time Mark said that, he started reaching for the yolk but the auto throttles were already off and thrust coming back. Mark got the reverse in first, and then got the speed brakes. There was never a transfer of control, the left seat pilot is always in command for aborts, and this was briefed ahead of time.

He called for the evacuation as soon as the airplane came to a stop, then he called DTW approach, and then they did the evacuation checklist. He read the checklist, and both pilots performed the actions.

He said there were no challenges with the evacuation, and it went right by the book. The flight attendants were professional. The team was even surprised that everyone was off the airplane.

They have trained for evacuations in the simulator. They were typical, and the scenarios usually the same. We train for them every proficiency training. It felt much different when it was real.

He described his overall health as “very healthy,” and worked out 4-5 times a week. He does not drink or smoke. He does not take prescription drugs, and there have been no personal, health or financial changes in his life during the past year.

Ameristar does not have an ASAP program, but they have an SMS program along with irregularity reports, and they go to him, Pat and the Director of Safety. He did not remember if they had a de-identified reporting system.

He started flying in 1999 with Ameristar Jet Charter, flying the Lear and Falcons, B737, DC9 and MD80. He became chief pilot in November 2016. Prior to Ameristar, his first flying job was in early 1999 flying Baron’s and C402’s for GTE Air in Dallas.

He said Ameristar was a “good company” and treated him well. They were one of the few companies that did not lay off a pilot during tough economic times. He was very familiar with their SOPs, and felt properly trained to handle the event.

He said their abort policy was that prior to 80 knots, they could abort for anything. Between 80 knots and V1, they should abort for engine fire, failure, or loss of directional control. After v1, “you go.” When asked if there was any guidance to reject after V1, he said they do not train or practice it. He added that with Mark’s experience flying the MD80, if he said he pulled back on the yolk and it would not fly, he believed him. There is no guidance for him to take control from the right seat, it was the flying pilot’s call and responsibility to conduct the abort.

He said he did not have any personal concerns about the winds that day. He did not remember feeling any pitch increase after the rotation call. For performance calculations, they always use the most restrictive weight values. Their actual temperature for the takeoff was 10 degrees.

They do not use flex thrust, only max thrust. The V-speeds were based on actual weight of the airplane.

It was windy that day, but he had no concerns about the airplane. They are pre-approved for their SMS. He was not sure who was responsible for completing the risk assessment sheet. This takeoff was low risk, but there were some high winds at the airport.

For takeoff power and clamp, the PNF makes sure the throttles are up to the bugs and cross checked with the EPR bugs.

He did not remember hearing Mark actually call "abort"

They had a formal process of documenting the differences training, and those are kept at the Dallas offices. There were no comments section for the ground school forms.

He said he was happy with their training program. He did not see anything needed to be added to their training.

Interview concluded at 1045.

### **3.0 Interview: Pat Hulsey, Ameristar Director of Operations**

**Date: April 11, 2017**

**Location: Ameristar Offices**

**Time: 0900 CDT**

Present: Present: David Lawrence - National Transportation Safety Board (NTSB); Richard Neibert - Federal Aviation Administration (FAA) and H. K. "Chip" Sieglinger – Boeing (via phone).

Representative: none

During the interview, Mr. Hulsey stated the following:

His name was Daniel Patrick Hulsey, and he was 66 years old. His title at Ameristar was Director of Operations. His background included a total of 14,000 flight hours. He started at a small Part 135 operator, was an instructor, and flew for Braniff for about 17 years. He was with Kitty Hawk for 7 years as the Chief Pilot and Assistant Director of Operations. In 2000 he became the Director of Operations at Ameristar and assisted in the initial certification. He was rated in the B-737, DC-9 and B-727. He had not flown the MD-83.

Ameristar Air Cargo was the Part 121 operation and employed about 60-70 people. The Ameristar Jet Charters was the Part 135 operation. There were two separate companies, and each was its own incorporated entity.

He was responsible and in charge of the Part 121 operation. He was also the liaison to the FAA, in charge of all the manuals, and in charge of writing the manuals (90%), and submitted all the

approvals. He controlled the OpSpecs, (Operations Specifications) and was the primary dealer with the FAA.

On the day of the accident, he got a call from the PIC (pilot in command) at about 1300 CDT, who said he had crashed and gone off the end of the runway. The pilot said everyone was ok, and he told the pilot to make sure everyone was off the airplane, the CVR (cockpit voice recorder) circuit breaker was pulled, and to get away from the airplane. He wanted to make sure everyone was off, secure the airplane, and since the pilot told him there was likely substantial damage, it would likely be classified as an accident even though the pilot hadn't described the damage to him. He then called the owner/president of the company, called flight control, then made a 3<sup>rd</sup> call to the NTSB and spoke with Lorenda Ward to give what sketchy details he had. He then called the POI (principal operations inspector).

They initiated their emergency response plan which included sending people home to pack. They had a short meeting at flight control, and were then dispatched with the part 135 pilots to fly to YIP (Willow Run Airport). He prepared several reports for the NTSB while he waited to fly up to YIP. He met with one of the pilots that evening, who gave him a "thumb nail" report of the accident.

The previous call he received from the pilot was about an hour or so before the accident, and he needed the temperature since the ATIS was down. He said he thought he only needed the temperature, gave him the RTMA (Real Time Mesoscale Analysis) that he got it off the internet, which was about 10.3C. This was the first time they had to use the RTMA for a temperature on departure. The PIC said that was about right, and he told the PIC to write that down on the release with his name. Probably about 30 minutes later, he shot a picture of the release to him via email. He said the PIC said the airport was very windy. He did not recall if the pilot mentioned that there was a power loss at the airport, just that he wasn't able to get the temperature. He thought maybe flight control was aware of the power loss.

They were having problems getting the flight plan filed initially. He did not remember if the PIC mentioned that the weather wasn't being reported. He just couldn't remember if the PIC said anything about the weather, but he may have.

He did not look at the weather prior to the departure, only after the accident. When asked if the lack of weather being reported at the airport met their OpSpec requirements for departure, he said as far as A008, it would because it only mentioned official weather reports and forecast, and the forecast was valid for that 24-hour period. He said their aircraft movements were predicated on the forecast, and that was what they were allowed to go on. He said prior to the accident, he thought they would need a valid weather report, but reading the OpSpecs, it does not say that.

When asked what the weather was at the time of the accident, he said it was VFR, and as pilots, they were trained to look out and determine, including things like runway assessments. The pilot was able to make the determination if the weather was IFR or VFR. The OpSpecs said that the reported weather conditions must meet certain requirements, and the pilot could determine those conditions. The weather on the last report said the weather was above their requirements, and the weather had not changed by the time of the departure. Even though the report was old, the

conditions had not changed. He said the OpSpecs did not say what the length of time was required for a report, and an ATIS or METAR was “historical” anyway. He said that all Part 121 movements were based on a forecast. Technically, if a report happened at 1653, and it was now 1953, and the conditions had not changed then the report was valid. There was no guidance on the area and it was a “grey area”. He said for the accident flight, they were legal to depart per their OpSpecs.

EWINS (Enhanced Weather Information Systems) was essentially their ability to use a commercial vendor for forecasting, and to provide a forecast outside of the NWS (National Weather Service). They used Jeppesen, and an example would be if YIP did not provide a forecast for the airport, they could obtain that from Jeppesen. They did not contact Jeppesen on the day of the accident since the YIP already reported a TAF and it was not necessary. He did not know if anyone else had contacted Jeppesen.

He said they did have a process in their weight and balance program to address sports team charters. It was not a requirement. They typically always used assumed weights unless they saw something that would require actual weights, like a military charter. They had the ability to use actual weights but had chosen to use average weights. They had done actual weights once in the past. They had the ability to mix and match actual and average weights, but they had not seen a need to do that. The Advisory Circular (AC) defines and validates the average weights they use. Ameristar uses those average weights and does not have the volume and scale to validate those AC weights, and they were not required to validate them.

He said he was familiar with the Boeing ops bulletin for 75 mph winds, and that language was in the DC-9 AOM, Volume 1, preflight section. That manual defined procedures for the crew, and the PIC was responsible for the preflight actions. When asked what the pilot’s responsibility was regarding the 75 mph wind limitation, he said the pilot would have to alert maintenance if they knew the winds exceeded that limit. He said that at Ameristar, they really do not have a process or procedure to monitor those winds. It was something they were looking at. There was no expectation for the pilots to monitor the winds when they were off duty since that would be duty time.

He said he believed the bulletin language was also in the AMM, and pilots were not responsible for items in that manual. He had never known of a situation that required them to do an inspection based on the 75 mph winds since typically if the winds were forecast to be that high, they would move the airplane out from that area. When asked who would he expect to monitor the winds, he said the only place that was 24/7 was their flight control area, and currently they did not have a procedure for that.

He said that as Director of Operations, when the airplane was parked and not flying, the responsibility for the airplane was to maintenance.

Their OpSpecs C064 covered IFR operations in Class G airspace without an operating control tower, and when asked if an airport that did not have an ASOS/AWOS met the paragraph A2 requirement to have an approved source of weather, he said the “or” in paragraph A2 made it difficult to say. The eligible on-demand authorization may be another interpretation.

He did not recall anyone making the statement to go look at the airplane at YIP because of the windy conditions, and he was not aware of the wind exceeding 75 mph. That limitation had not been emphasized over the years.

When asked if the pilots could have calculated a crosswind component prior to their YIP departure, he said no. They could get close by looking at the wind sock, and it would have been an approximate crosswind. Boeing did not have a crosswind limit for the MD-83 in the AFM, but he said he believed Ameristar did have a limitation in their COM. He did not think the crosswind was an issue since the crew maintained the centerline on the departure.

He said the pilots were allowed to depart YIP because they had the forecasted weather for the airport, and that was his belief even though they did not have an ASOS or ATIS being reported. He said pilots were not qualified weather observers from a technical standpoint, but pilots could determine if it was IFR or VFR.

They had operated into airports when the airport did not have weather being reported, and they would typically have a qualified weather observer issue weather for that landing. An example would be when ADS (Addison Airport) was closed at 2200 and there was no weather being reported, they would bring in a weather observer to issue them weather. For takeoff, he was not 100% sure if that was the case.

When asked if there was anything he would have done differently on the day of the accident, he said not really. He believed the flight controllers were properly trained and did their duties. They reviewed their RTMA procedures and they did those correctly.

Interview concluded at 1015.

#### **4.0 Interview: Richard Cole, Ameristar Director of QC/QA**

**Date: April 11, 2017**

**Location: Ameristar Offices**

**Time: 1030 CDT**

Present: David Lawrence - National Transportation Safety Board (NTSB); Pat Hulsey – Ameristar; Richard Neibert - Federal Aviation Administration (FAA) and H. K. "Chip" Sieglinger – Boeing (via phone).

Representative: none

During the interview, Mr. Cole stated the following:

His name was Richard Allan Cole, and he was 50 years old. His title at Ameristar was Director Quality control, Quality Assurance. His background included working for Kalitta for 14 years, starting on the ramp in 1986 and worked his way up to lead mechanic there. He worked for Northwest Airlines for 1.5 years as a line mechanic until 9/11 happened, then went to ANC as a Director of Maintenance for a small Part 135 company for 3 years. He then went back to Michigan with Ameristar as a line mechanic from 2004-2007, went back to Kalitta as a line lead

mechanic from 2007-2012, and then back to Ameristar as station manager in YIP. He became the Director of Maintenance of Ameristar Air Cargo in Addison, Texas 2 years later, and then 6 months ago assumed his current position.

His responsibilities were to oversee Ameristar's required inspection program, and he maintained the maintenance programs to include the Camp program, docs current. He provided oversight to ensure the programs were current, and the Director of Maintenance's function was to implement the program.

He worked with the Director of Operations on a day to day basis for things that would come up regarding the airplanes, like an STC. He also worked with flight manual supplements. He was also in charge of the drinking water program on the airplanes for the EPA. If there was a positive sample, he would get with the Director of Operations.

He did not necessarily work with pilot procedures unless there was a question from the Director of Operations

When asked what his greatest challenge was, he said working with the FAA. He primarily worked with the PMI at the FAA.

On the day of accident, he was on the phone with PMI when the Director of Safety came down the hall and notified him that they had an accident. He got off the phone talked to Pat. After they found out everyone was ok, they assembled the go team. He was on the structures group and systems group for the NTSB investigation.

His position was a Part 119 position, and his duties were listed in the GMM.

When asked about the Boeing 75 mph limit, he said the bulletin was not in the AMM, but the information from the bulletin was in Chapter 5 of the AMM. If there were winds over 75 mph, a physical and visual inspection was required on the airplane. When asked who did those inspections, he said it should be driven by maintenance personnel since the flight crew could not do that inspection. He said Ameristar did not have procedures in place for notification of winds in excess of 75 mph. When asked who should be responsible for the inspection, he said it should be maintenance to do the inspections. He said it would take a system to monitor the airplane and airport at all times to determine who would notify maintenance of the winds. He said the most reasonable people to monitor the winds would be flight control. On the day of the accident, no one notified maintenance that the winds may have exceeded 75 mph. Pilots have a preflight duty, but not related to the physical and visual inspection related to the Boeing bulletin.

He had seen wind damage an aircraft before when sitting on the ground, and said he saw that in Anchorage with a different operator when wind came through and destroyed multiple airplanes. He had never heard of damage to an MD-83 due to winds on the ground.

The guidance they had was to place the airplane into the wind on the ground. They did, on occasion, park the airplane with the reversers deployed to prevent wind through the engine blowing the inlet covers off. There were no gust locks on the MD-83.



Once the pilots were off the airplane, the mechanics reviewed the logbook, and checked for any open write ups. The airplane would then sit at the airport until the next service check or when it departed the airport.

One or two trips prior to the accident, the airplane had an autothrottle issue on one of the engines. There were no deferred items on the accident flight.

He did not think a pilot would notice elevator damage during their flight controls since the control tabs are what is connected to the control column. There is a hydraulic boost to position the nose down for a stall recovery. He did not think there would be any tactile feel in the column with a damaged elevator.

Post-accident, Ameristar was considering developing the notification for monitoring the winds on the airport.

He ensured the airplane was weighed properly, and that information was provided to the Director of Operations, and the pilots conducted the flights weight and balance. In YIP, the mechanics would assist the ground loaders in loading the baggage.

YIP had 5 line mechanics, and one person in the stock room. They worked on day shifts with one person on call for after hours. They did not have anyone on site working 24 hours. The mechanics did have access to the internet.

When asked what check of the airplane would require the mechanic to go up to the elevator to check its movement, he said the A2 check, required lubrication of the system. There was really nothing else that drove the mechanic up to the tail except a visual inspection from the ground. The A2 check was done every 240 days or 900 hours. This check was performed by a qualified mechanic. The last A2 check for the accident airplane was completed December 30, 2016. Most all of their inspections were calendar based since the airplanes did not fly that often.

He said they did have access to a hanger in YIP, but it would have taken up two bays to park. It would have been available to them, but it was not requested.

Interview concluded at 1110.

## **5.0 Interview: Darren Diehl, Ameristar Flight Follower**

**Date: April 11, 2017**

**Location: Ameristar Offices**

**Time: 1130 CDT**

Present: David Lawrence - National Transportation Safety Board (NTSB); Pat Hulsey – Ameristar; Richard Neibert - Federal Aviation Administration (FAA) and H. K. "Chip" Sieglinger – Boeing (via phone).

Representative: none

During the interview, Mr. Diehl stated the following:

His name was John Darren Diehl, and he was 46 years old. His title at Ameristar was Flight Follower. His responsibilities included creating the flight plans, getting the weather, obtaining the fuel loads, and working with the ground handlers and truckers. On the day of the accident, he was the official flight follower for the accident flight, and was training a new flight follower. He reviewed all the paperwork sent to the crew, and oversaw all the trainee's work.

His background included work in the telecommunications industry before getting laid off. His brother previously worked at Ameristar. He got his dispatcher's license in 2004. He said that all but one of the flight followers have dispatcher's licenses, and that one person does not work on the Part 121 side of the operations. He thought there was a requirement for Ameristar flight followers to hold a dispatcher's license, but was not sure. They had about 13 flight followers total, and they worked shifts.

On the day of the accident, he tried to get the paperwork done for the crew early so they would have it for prior to their repositioning of the aircraft. He had flight planned both the YIP-IAD and IAD-LAF flights and sent it to the FBO on the west side of the airport for the crew to retrieve. They had some problems getting the first leg filed, and he planned to send the paperwork to the east side after the airplane was repositioned for passenger loading. Once the airplane was repositioned to the east side ramp, most all of his communications were with the ground security coordinator (GSC) as the passengers starting showing up in two different waves to the airplane. He did not have contact with the flight crew.

They went through a shift change at Ameristar, and he clocked out at about 1400 CDT. A few minutes later he found out that the flight had gone off the end of the runway, and he clocked back in to assist in notifying people and find out what happened. He continued to gather information, but had not talked to the crew.

For the first flight plan, he tried to get it done before crew showed for airport. When he realized that flight plan did not get filed, he filed another flight plan, which was about 1 hour before departure

He said they used Jeppesen to develop their flight plans and get their weather, and was part of the Ameristar system. The weather would automatically populate into the paperwork for the pilot. The ultimate source of the weather was NWS. He did not recall if anyone contacted Jeppesen regarding the weather at YIP.

When asked if there was a weather source available at the time of departure, he said that to his knowledge there was weather reporting since the METARs he sent the crew were the most recent ones available, and there was no indication in those reports that the weather was not available at the airport. He knew there was a power outage at the FBO since they had problems printing up the flight paperwork, but he was not aware that the tower had closed, the airport was uncontrolled, and the ASOS and ATIS were not providing weather. He remembered talking briefly with the PIC before the airplane was repositioned, and briefly to the FO afterward, but did

not recall if either pilot told him about the tower and weather not being available. He said Ameristar was authorized to depart from an uncontrolled (no ATC services) airport.

When asked if weather services had to be available at the airport at the time of departure, he said he was not sure, and for this flight there was nothing to indicate that the weather wasn't available to the pilots. He said the METARs showing that the weather sources were no longer working at the time of the accident were not made available to him since he had already flight planned the flight when the weather was available. He said that had he seen the METARs showing the weather no being available, he would have called the PIC or Director of Flight Operations for additional guidance.

When asked about the weight and balance, he said that was the pilot's responsibility. Most all of their passenger flights were sports charters, and they used assumed weights for all their charters. The payload weights also used assumed weights, plus a fixed amount for material already on the airplane. When asked why Ameristar did not use actual weights for sports teams, he said that he had always used the assume weights.

When asked about the Boeing Bulletin for the 75 mph limitation requiring a visual and physical inspection of the elevator, he said he did not have knowledge of that bulletin prior to the accident, and did not know about it at the time he completed the paperwork for the flight. He did not know if it was the pilot's responsibility or mechanic's to monitor the winds when the airplane was on the ground. He did not know if the pilots were responsible for the information contained in the maintenance manual. He said he did not monitor winds when the airplane was sitting on the ground.

He had received training on the DC-9 Aircraft Operations Manual (AOM) in ground school and during recurrent.

Even though flight control did not monitor the winds, they did monitor other weather like thunderstorms and hail so they could move the airplanes if necessary.

When he generated the new flight plan, it was time stamped for 1713Z. He signed the original flight plan at 1700. When he amended the flight plan to refile it, he only changed the flight plan number and routing, and did not change the weather in the paperwork which showed the 1653Z weather. He said they used an approximate temp of 11C for the flight plan.

He did not give the RTMA temperature to the crew, and was told that the Director of Operations provided that directly to the PIC.

He said YIP provided their own TAF, and it covered the accident time period for 1600Z-2100Z. He had planned on the departure runway as 23L based on the forecasted winds in the TAF.

For ground handling, he only set up the ground handlers, and did not train them or talk to them.

Interview concluded at 1210.

## **6.0 Interview: John Polizzi, Ameristar Director of Safety**

**Date: April 12, 2017**

**Location: Ameristar Offices**

**Time: 0915 CDT**

Present: David Lawrence - National Transportation Safety Board (NTSB); Pat Hulsey – Ameristar; Richard Neibert - Federal Aviation Administration (FAA) and H. K. "Chip" Sieglinger – Boeing (via phone).

Representative: none

During the interview, Mr. Polizzi stated the following:

His name was John Polizzi, and he was 57 years old. His title at Ameristar was Director of Safety. His background included working for Sky Lease Air Cargo for 6 months as a pilot on the B747-400. He flew for Evergreen for 30 years as a pilot, the majority on the B747, with 21 years as a captain, and 11 years as a check airman. He also flew the B727 as a captain, first officer, and flight engineer. He had been with Ameristar for about 3 years, all as Director of Safety and flight crew member, but did not currently fly.

His responsibilities were included in the GOM, Section 1.2.3, and in summary he reported to the President with a “laundry list” of items, and reported safety issues if he saw a need.

On the day of the accident, he was in the office conducting normal office duties when he heard a conversation between Pat had with Andreas, and that was when he was told about the accident. He went down to flight control advised them to find location of president and vice president of the company. They formed up as a group at the office.

They used the emergency response checklist, looked at the functions, and everyone was doing their functions. The checklist was actually in the Safety and Emergency Response manual. He looked at his own plan, and made sure the phone calls were made. He did not notice any challenges with executing the plan.

They planned a desktop drill once a year. The last one was Thursday, and they had an SMS training class on general policy and included the emergency response plan.

When asked about their SMS program, he said they had Sections A, B, and C validated. The emergency response plan had also been completed. They were in the process of writing subpart E and F currently.

They did not have an ASAP program at Ameristar, and there were no current plans to implement one. They had a manual discrepancy form, safety discrepancy form, and with SMS they had a safety hazard report that could be filled out by the employees. He received these reports. They also had a safety hot line, which eventually made it to him, along with any safety emails. When asked if they had any formal de-identified reporting, he said the hazard report could be submitted anonymously. He did not get these reports very often.

Ameristar employees were not part of any union, though some employees were under a training contract.

Safety Status Reports (SSRs) discussed the current status or condition of a department, or the company as a whole. Under SMS, these were considered evaluations. Maintenance would have a safety status report through the CASS program. Safety status reports were the audits he performed for the flight ops program. Inflight would use the exit row seating audit or carry-on baggage audit.

They did these audits on a monthly basis, which included a review flight releases, log books, and hazardous materials. The flight release audit would review weight and balances and load manifest. These audits made sure the requirements of each document were correct and there were no exceedances.

When asked if the safety department had reviewed the use of average versus actual weights on the company charters, he said there had been no review since he had been at the company, but they were allowed to use actual weights.

His main interaction with the FAA was through the 3 principal inspectors, and they spoke weekly. They had a very good report. All 3 inspectors had recently attended their SMS training.

The only observation work he did was ground observation when the airline was at the airport. There was no program for flight followers to get out and observe on charters. They are a small company, so they did not have LOSA or FOQA or ASAP programs. Data collection was primarily through their irregularity reports and logbook.

The irregularity reports went to the Director of Operations and Chief Pilot, and were forwarded to him. They would sit down to review the reports to see if there needed to be improvements. Normally it was the PIC that would write an irregularity report, but actually anyone can complete one. For their small operation, he would typically see about 2 reports per month.

For their fatigue risk management plan, they basically leave it up to the individual to announce if they are fatigued, if they are, they are taken off the scheduled. It is trained in initial and recurrent.

His biggest challenge in safety is to get people to participate. He sends out emails, makes phone calls, and attempts to facilitate communications. For their operation, he does not distribute a newsletter. His biggest satisfaction is when compliance is met.

He reported to the president/owner.

When asked about their SMS, he said Sections A, B, C and D had been validated, and 5 or 6 demonstrations completed. Every flight had a risk assessment, scored 0-30, low/medium/high. It included weather, rest requirements, mechanical reliability. Flight followers checked the applicable boxes, and scored by number. A score of 10 or less was considered low risk. The form was distributed to the pilots in their flight release paperwork.

Flight followers ascertain the weather, the rest requirements, any MELs, and they have all the information needed to complete the risk assessment form. Any score that was 20 or greater would have to have the Director of Operations or chief pilot's approval to conduct that flight. The PIC always had the right to discuss any flight with the chief pilot or Director of Operations.

He did not get any emails or phone calls with concerns about the winds at YIP on the day of the accident.

In SMS, the accountable executive would be the president/owner of Ameristar.

There were different sections of the SMS part 5 program. Those were the rules of the program. The implementation date was to comply by March 9, 2018, and Ameristar is on track to comply.

When asked about the VP, her role in the emergency response plan was to fulfill the obligations of the president, and had emergency authority.

They had about 16-17 individual pilots, and had about 20 Flight attendants. The pilots flew about 20-25 hours per month. By policy, pilots had an 18-day schedule which was on-call for the cargo operations. The average trip was about 1-1.5 hours. A handful of their pilots were dual qualified.

When asked about the rest requirements, he said on the cargo side they complied with Subpart S requirements, and on the passenger side they complied with Part 117. Typically, their pilots spent more time in hotels than actually flying.

Aircraft audits encompassed a review of the manuals, the AOM, Jeppesen revisions, latest up to date revisions, and all emergency equipment. They liked to get those reviews done by the first crew to fly that airplane on the first of the month.

They did not have a LOSA program, but conducted line flying audits by check airman during line checks.

He estimated they conducted about 20 audits per month.

Interview concluded at 1000.

**7.0 Interview:** Willard "Mac" McMillen, FAA Principal Operations Inspector (POI)

**Date and Time:** May 11, 2017 1430 CDT

**Location:** via teleconference

**Present:** David Lawrence - National Transportation Safety Board (NTSB); Richard Neibert - Federal Aviation Administration (FAA) and H. K. "Chip" Sieglinger – Boeing; Pat Hulsey – Ameristar.

**Representative:** Mark Tomasich - Litigation & General Law Division for the FAA

During the interview, Mr. McMillen stated the following:

His name was Willard Francis McMillen (Mac), and he was 62 years old. His title was Principal Operations Inspector (POI) for Ameristar Air Cargo, and he had been their POI since October 2015. His roles and responsibilities as POI included oversight of the operations since he was the operations inspector, which included everything from their daily operations, training programs, cargo programs, and safety programs.

His background included beginning to fly in 1975, and he majored in aviation in college. He was in the industry for about three years, and was a test pilot for STC modification work. He flew for the commuters and was a captain there. He flew for a total of about 7 different carriers, including the majors up until 2001 when he first got on with the FAA. He had an ATP, flight engineer, advanced ground instructor and drone pilot certificates. He was type rated on the B-727, B-737, B-757, B-767 and DC-9. He flew the DC-9 -30 and -50 series airplanes for the old Eastern Airlines.

On March 8 in the afternoon, the Director of Operations (DO) called him to inform him about the incident, which is what they were calling it early on. He stated that the DO then called his office manager to notify him of the incident. He talked to DO to get the names of the pilots, find out what happened, and learned that the crew did an aborted takeoff due to no rotation from the elevator, and they had a safe evacuation in under a minute. He got the crew names, pulled files since they were check airmen, and was getting ready to go over to the Ameristar offices which were about 30 minutes away when he was informed that the Detroit FSDO (Flight Standards District Office) would handle the investigation and he would remain in the office to provide the investigation team information and assistance. He then called Ameristar to secure all the files for the investigation team.

Both pilots were check airmen, but he did not know them “really, really well.” He knew the chief pilot, but not the captain in the left seat. He had reviewed their files, and both pilots seemed like “outstanding people” on their performance in the simulator and leading up to their certification as check airmen.

He said he and the DO talked just about every other day, and also talked often with the Director of Safety frequently since Ameristar was implementing SMS (Safety Management System). He also liked to get over to Ameristar at least every other week. He had sat in on most all the Ameristar training that he could, including some flight attendant initial and recurrent training and new hire or check airman ground schools. The DO regularly informed him of when classes were being taught, and he liked to be hands on with the operations.

Ameristar was the only certificate he managed as POI, and that was his only role with the FAA.

When asked about the Ameristar SMS implementation, he said they were about 51% complete, and they had just submitted sections E and F. He was heading over to Ameristar next Thursday to sit down with the safety department to go over the program. He said their SMS implementation was “moving right along.”

Ameristar did not have an ASAP (Aviation Safety Action Program) company since they might be too small to support it, but they did have captain reports and suggestions boxes. He had not seen any of those reports.

As POI, he had responsibilities for the Ameristar AOM (Aircraft Operating Manual) Volumes I and II. When asked about the required visual and physical inspection of the flight controls after the airplane had been subjected to winds of 75 mph, he said he was familiar with the Flight Ops bulletin dated 2001. He said he “had no idea” that this guidance was located in the Ameristar AOM for the pilots. He said a lot of other airlines did not know about this limitation since most all of them were calling him up to ask him about it after the accident.

When asked if he knew if Ameristar had a policy that defined who would be responsible for monitoring the winds on and airplane to ensure they had not exceeded 75 mph, he said “that one I do not know,” and he would have to research their dispatch procedures. When asked if the FAA was reviewing operator manuals to see if anyone had a policy of identifying who would be responsible for monitoring the winds, he said he had seen no statements, bulletins or amendments addressing the issue.

He was read the passage from the Ameristar Air Cargo General Operations Manual (GOM, paragraph 4.2.10) regarding weather, sources of weather information. When asked if it was permissible for a Part 121 supplemental carrier to depart when there was no weather being reported at the airport, he said that he understood that based on the GOM, if the weather was more than an hour old, the captain was required to get new weather and note it on the paperwork. He believed that the captain had called the DO and gotten the RTMA (Real-Time Mesoscale Analysis) winds and weather prior to departure. When asked if, with no weather being reported at the airport at the time of departure, were the pilots legal to depart, he said that if the pilot could not get an update to weather that was an hour old he would say they were “grounded” and could not depart.

He had responsibility for the Operations Specifications (OpSpecs). When asked about OpSpecs C064(a)(2) regarding needing an approved weather source or “in accordance with the provisions for conducting the flight under the eligible on-demand authorization,” he said he was looking at a copy of that section of the OpSpecs and he said “he was drawing a blank” and would be happy to get back to the NTSB with an answer.

The interview concluded at 1510.