

Factual Report – Attachment 1
Interview Summaries

AIR TRAFFIC CONTROL

DCA19FA089

Interviewee: Michael Yanis – National Airspace Operations Manager (NOM)
Date / Time: March 18, 2019 / 1230 EDT
Location: ZBW ARTCC
Present: Don Eick – NTSB, Nathan Doble – NTSB, Chris Kerrigan – FAA, and Sarah Owens – NATCA
Investigator: Brian Soper

During the interview, Mr. Yanis stated the following:

Mr. Yannis had been a technician with the FAA since June 2002, when he was hired by Boston Terminal Radar Approach Control (A90). In January 2013, he accepted a position and transferred to Boston ARTCC (ZBW).

He worked the mid-shift and his regular work schedule was 2100-0700 Monday through Friday with regular days off on Saturday and Sunday. He worked his normally scheduled shifts for the week leading up to and the day of the accident and did not recall working any overtime.

He was the National Airspace System Operations Manager (NOM) on duty at the time of the accident. He recalled that the evening before the accident occurred, there had been a report of a problem with the instrument landing system (ILS) localizer at Presque Isle (PQI). Specifically, he recalled the Operations Manager in Charge (OMIC) approaching him that evening as he was walking over to the En Route Automation Modernization (ERAM) processors and saying that one of the controllers had just received a report from a pilot that landed at PQI that the localizer was a “click” to the right of centerline. He and the OMIC had a brief conversation about ILS, localizer, and glideslope and what they felt their next steps should be and guessed there was sort of an agreed assumption made that they would be looking for a second aircraft verification.

When asked if there was a requirement for him to log this type of report, he said that it was a very unusual circumstance in this case, because as an air route traffic control center (ARTCC) they do not deal with bringing an aircraft to the ground very often and just did not have a lot of involvement with these types of reports. He said that he was familiar with the ILS from working at other facilities but did not have a working knowledge of the system. He knew what a localizer looked like, but they did not have an ILS technician working at ZBW. He said there was a process in place for when they would receive reports of issues (often just verbal), and his first step was to ascertain whether or not it was an equipment issue or an aircraft issue, which was normally accomplished by having a second aircraft verify the issue. The reporting was highly dependent on the scenario, and the interaction between technical operations (tech ops) and air traffic control (ATC) varies based on the issue being reported. He felt that as a malfunction report, this report of being a click off did not sound that bad.

He said that if he had received a second report, he would have called the Atlantic Operations Control Center (AOCC) in Atlanta, Georgia because they were the first contact for field/airport-based equipment. Once a verified report had been made to the AOCC, he expected that they would act as appropriate. He was not sure exactly what they did, but knew they had a procedure for following up on reported issues. Any issues with equipment that was not actually owned or maintained by ZBW would be reported to the AOCC. When asked if he would log this

type of report to AOCC, he said that it was not a normal practice to log it and had an expectation that the AOCC would ensure equipment was NOTAM'd as appropriate.

He said that the ILS equipment at PQI was maintained by technicians out of Bangor, Maine. He said the AOCC would be responsible for contacting the Systems Control Center (SCC) in Bangor to initiate any review or maintenance that may be needed.

In summary, he just assumed there would be a second report, and that ATC would report if they had received a second report that verified the issue. He just assumed the absence of a second report from ATC was an indication it was no longer a problem.

Conversation concluded at 1315 EST.

Interviewee: Rodney Wilcox – Operations Manager In-Charge (OMIC)

Date / Time: March 17, 2019 / 1330 EST

Location: ZBW ARTCC

Present: Don Eick – NTSB, Nathan Doble – NTSB, Chris Kerrigan – FAA, and Sarah Owens – NATCA

Investigator: Brian Soper

During the interview, Mr. Wilcox stated the following:

Mr. Wilcox's air traffic control experience began in the United States Navy (USN) where he served on active duty as an air traffic controller from June 1988 through May of 1994. After being honorably discharged from the USN he worked briefly at three different contract towers in 1997-1998 before being hired by the FAA and accepting an assignment to Akron-Canton Air Traffic Control Tower (CAK ATCT) in May 1998. In August 2000 he transferred to Manchester ATCT (MHT) where he worked until transferring to Boston Terminal Radar Approach Control (A90 TRACON) in March 2004. In October 2012, he transferred to ZBW ARTCC.

He had been certified as an OMIC in January 2016 and October of 2016 and was current and proficient on the position he was working in accordance with facility standards. He had no documented operational incidents or history of suspensions at ZBW ARTCC. He had collateral duties as BSAT, SUPCOM Chair, and was the scheduling supervisor. He had not been on any recent details. He recalled nothing remarkable about the 72 hours leading up to this shift, with routine daily activities, sleep, and meals.

His operating initials were SV and his supervisor of record was Mike Dillon. He possessed a current second-class medical certificate and his last ATC physical had been conducted in October 2018. He had a requirement to wear corrective lenses while performing air traffic control duties and was wearing them on the night in question. He was prescribed maintenance medication for high blood pressure, which he was taking as prescribed on the night in question. He was a certified private pilot, however, was not current.

On March 2, 2019, he was working the mid-shift, which he said he worked once about every other week and stood OMIC day shifts a couple of times a week. He recalled the weather

being VFR that evening and did not recall any precipitation. He thought there were the standard AIRMETS out during that shift but did not recall any SIGMETs or CWAs. During the evening in question, on a scale of 1 to 5 (5 being the heaviest) he classified the traffic volume as 3 and on a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as 3 that evening. He said that a relief briefing was conducted when he assumed the position, and that it was recorded, and a checklist was utilized.

When asked if he knew anything about there being a report of the ILS being out of service a few days before the accident he said that he had relieved someone at about 2315 and at about 2330-2345 Jim Lund (radar controller from Area D) reported an interesting situation. A CommutAir pilot who broke out at about 3,000 feet on approach into PQI reported that his ILS needles showed a half scale deflection to the right. Mr. Wilcox passed that information along to the tech ops NOM on duty at the time, Mr. Mike Yanis. He said they had a 5-6-minute conversation and described to Mr. Yanis the situation verbally, using a notepad to illustrate to him what that would look like. He did not provide any written documentation of the report. When asked if this was logged into the facility log, Mr. Wilcox said that it was not, because they still needed a second report to verify, and that was the last commercial flight into PQI that night. When asked if his information was passed down to the OMIC that relieved him, he said he might have discussed it briefly, but it was not on the relief briefing and only would have been had it been a verified outage.

When asked what tech ops did with information like this when it was reported, he said that he did not know what they did with the information, or if it was documented in their logs. He assumed that tech ops would have handled coordinating a second report from ATC when ops resumed to that airport, and he did not pass the information down nor instruct anyone to put it into the Information Display System (IDS). With regards to log entries, he said OMICs only made certain entries for things that generally were related directly to ATC; NAVAID information is not typically something they would log. When he would receive a report of malfunction to equipment like this, he would provide the information directly to tech ops and if they feel it is something that is worthy of a follow up, they would come back to ATC and request from them whatever they needed (i.e., a second report).

He did say that tech ops provided ATC with an equipment outage sheet daily, and there are procedures to follow if applicable. They only logged equipment as down if there had been a second report that verified the initial report. He added that typically, a second report was always required for verification. In this case, he recalled telling tech ops that he did not know when there would be an opportunity for a second check but was clear that he felt it was tech ops responsibility to request a second check if/when required.

He did not know if this information had been passed down by Mr. Lund to the controller that relieved him but knew that he had stated it was the last flight scheduled into PQI that night. The airport was not actually closed, but he had no more air carriers scheduled into the airport. When asked if he recalled there being any reported issues with the AWOS or RVR at PQI, he said he did not.

Interview concluded at 1410 EST.