NATIONAL TRANSPORTATION SAFETY BOARD

Office of Aviation Safety
Washington, D.C. 20594

December 22, 2021

Attachment 1 – Interview Summaries

OPERATIONAL FACTORS

DCA19FA089

Interview: Gary Robert Layne II, CommutAir FO
Date/Time: March 7, 2019, 0900 EST
Location: via telephone
Attendees: Marvin Frantz, Katherine Wilson – National Transportation Safety Board (NTSB); Patrick Hempen – Federal Aviation Administration (FAA); Cory Hamernik – Air Line Pilots Association (ALPA); Zack Barrett – CommutAir

Representative: Neil Davis, ALPA Legal

During the interview, FO Layne stated the following:

He was 51 years old and was a first officer (FO) for CommutAir on the EMB 145. He had held that position since May 17, 2018. He had about 5000 hours total time, about 500 hours of which were on the EMB 145. All of his time was in fixed-wing aircraft. He held an ATP (airline transport pilot certificate) and EMB 145 type rating, as well as a certified flight instructor (CFI) certificate for single-engine and multi-engine land (SEL and MEL, respectively) aircraft.

In the military, he was in the US Army Corps of Engineers for 10 years and special ops for 10 years. He did not fly in the military; he was a 12B-combat engineer and his highest rank was sergeant.

The accident flight was from Newark Liberty International Airport (EWR) to Presque Isle International Airport (PQI). Presque Isle was the "most austere" airport with the least services. The crew briefed the Runway 01 approach and it was going to be instruments all the way down with a ½ mile visibility, light snow and a 1000 foot ceiling. He commenced the approach with the autopilot on. While on the instruments only, he could see the ground in his peripheral vision so he thought he could see outside. He could not remember where on the approach that he transitioned from instruments to the outside to look for the runway and could not recall if the captain said she had the runway in sight. He expected to see the runway when he looked outside but what he saw was "white on white". There was a small structure with an antenna that he saw which was part of the runway environment but not the runway itself so they executed a missed approach. Boston Center asked them if they were flying the published missed approach procedure and the captain told them yes. Boston Center also asked if they wanted vectors back to the runway. He gave a thumbs up to the captain and they returned to the airport for a second time. The captain asked him if he was okay to fly the approach and he said he was. The crew had a deliberate conversation about the approach and when he transitioned to visual for landing. They discussed him staying inside until the decision height or when the captain said "runway in sight". He liked to hand fly the approach but kept the autopilot on until 200 feet. He stayed inside until the last second when the captain said runway in sight. He thought she told him to turn the autopilot off. He stayed on the flight directors and when he looked out he expected to see the runway but did not. He saw white on white with blowing snow. It was "difficult at best" to understand what he was seeing because everything was covered in snow. In hindsight, he thought they were seeing the right edge of the runway and the left edge of the taxiway. In their minds, he thought that was what they misinterpreted as the runway. There was very little time from when he transitioned outside to

interpret what he saw. The airplane touched down. There was “almost zero time” to figure out what he was seeing.

They were off the runway by 100-150 feet.

He did not recall briefing the autopilot but the pilot flying would tell the other crewmember when the autopilot was being turned off. His process was to turn it off when he was comfortable with how the approach was set up. He turned off the autopilot on the first approach when he had ground contact. For the second approach, the crew discussed keeping it on “all the way”. He thought the autopilot brought them to the same spot as the first approach. The big difference between the two approaches was that he was looking outside and hand flying earlier on the first approach.

He flew into PQI about 5 days before the event. He was the pilot monitoring (PM) and they flew the same approach. They noticed an incongruency between the pink and green needles. Before he departed Newark with the accident captain, he told her about it.

He clarified that the pink needle was from the FMS and the green needle was from the ILS localizer/glideslope. He knew that Norfolk had a similar issue when intercepting the localizer for runway 5. They would stay on the pink needle until it settled down and then would transition over.

When flying into to Presque Isle on the accident flight, he did not see any anomalies or that what was being displayed was incorrect.

Regarding his previous trip into Presque Isle, the captain of that flight did not think they needed to complete an ASAP report.

The accident crew did turn on the runway lights. He was familiar with the airport and knew that CTAF frequency was 122.8 but the lighting frequency was 122.6. He believed that was because of another nearby airport that used 122.8 for its lighting.

After going missed, he believed the captain called ground maintenance to make sure the lights were on. He asked the captain if she saw the lights because he wanted to know what he should expect to see on the second approach and referred to his “mental map”. He still did not know what he was going to see when he looked out the window. On the first approach, he did not recall the captain calling the lights in sight. He did not recall this on the second approach either. He did not see the lights on either approach.

When the captain would call “runway in sight”, he would repeat that and transition outside. That did not mean that he saw the runway but confirming what the captain saw. He and the captain were “hyperfocused” knowing the airport had snow on the FMS and speed. They did not want to be high and fast or low and slow. He was staying in the airplane until the captain said runway in sight; that was the trigger for him to transition outside. He thought he also turned the autopilot off about the same time. He thought that the airport in sight was the trigger for all of that action to take place. On the second approach, he looked up and saw a “sea of white”. There was no distinguishable feature to say “that is the runway”. He thought he asked the captain “do you see it?” He fully expected to see the runway because the captain said she saw it. He felt there was an illusion because

from his perspective it looked like they could see farther than they could. Things did not look the way they were. He did see a linear type structure to the left and right but he believed that was the runway and taxiway. He could not 100% say it was or was not the runway.

It was a function of time that was different from the first to second approach. He expected to see the end of the runway but saw a structure with an antenna in front of them. They knew that was not right so they did a missed approach. On the second time, he was not looking out so he did not see the antenna because they were on top of it when he transitioned outside.

Additional information for the airport was in the release, on the 10-7 page, and in the NOTAMs for the airport, but there was no specific training on this airport. He had probably flown into Presque Isle 7-8 times and considered himself comfortable with the airport.

He was wearing his shoulder straps for landing.

Either pilot could call for a go around.

Asked when the pilot flying (PF) should look outside, he said it was when the PM stated that the airport landing lights were in sight, which also allowed them to continue down 100 feet more before committing to landing or going missed. The PM should make the call about what was seen when it was seen; the PM should not wait until decision height.

Regarding standard callouts at minimums, the PM would call the lights in sight which allowed the crew to descend an additional 100 feet. The second call would be "runway in sight" and the clock position. If the runway was not at 12 o'clock, something was wrong. It would not be normal for the PF to stay inside on the instruments below minimums if the runway environment was in sight.

He confirmed that he did not see the runway lights during the approach.

He did not recall any specific training for runways covered in snow. Special airports were covered and they had their charts so they knew what to expect. There was no training for weather or time of year operations specific to the airport environment.

He believed their alternate airport was Bangor. There was no company policy on when or where to divert to; it was a crew discussion with dispatch over ACARS.

He had flown to Presque Isle when there was snow on the ground but on the accident flight, the snow was measuring in feet and was way more than before. It was "indistinguishable" from his previous times there.

After the accident, he was prescribed Baclofen (10 mg), a muscle relaxant for pain, and Motrin (600 mg), both of which he had taken the day of the interview, but they did not alter his thinking and believed he was accurately recalling the events on the day of the accident.

He completed a post-accident drug and alcohol screening at the hospital. He did not believe he had received any medications at the hospital before he completed the test.

He had not been involved in any accidents or incidents previously. He had never been disciplined on the job nor received any commendations or atta boys.

There was extra workload on the flight because of the nature of the flight – Presque Isle brought extra stuff to do and the weather compounded the situation- but he felt like the crew could handle the workload.

He had a first class FAA medical certificate with the limitation that he must have readers in his possession. He did not have a prescription for his glasses. He was wearing his readers at the time of the accident.

He had no problems with his hearing. He did not use tobacco products and occasionally drank alcohol, the last time being more than 2 weeks before the accident because he recently had the flu. He never missed work for being sick until the trip before the accident flight. He called and told the company he could not continue the trip and to put him on the sick list; he thought that was Saturday, February 23. He flew home, arriving about 1800-1830 and went to a walk in clinic. He tested positive for the flu and was given prescription medications including a 5-day Zpack. He had to fly on Monday, March 4, and asked the doctor if he would be better by then. By Sunday, March 3, he felt much better. He finished his last pill on Monday, March 4, when he came back to work.

He commuted from his home in Palm Beach, Florida, to Newark on Sunday, March 3, because he was flying the first flight of the day on Monday. It was the company's policy for a commuting pilot to have 2 flight options. He chose a United flight arriving between 1700-1900 and a JetBlue flight arriving between 2030-2200. The United flight was cancelled and the JetBlue flight was delayed. He arrived at Newark about 2300-2330 on Sunday night then the van to the hotel was late. When he got to the hotel around midnight, there was a problem with his paperwork and he did not have a room. After getting a room, he was in bed by 0100. He slept until about 0600, had breakfast, then took the 0800 van to the airport so he would arrive in time for his 0845 report time. He felt "normal" on the day of the accident; his only issue was that he was coughing. He felt rested and fine. He had been resting a lot at home before the trip because he was sick. He went to bed earlier than normal and did not think he left the house. He was "laid up" and slept in, relaxed and went to bed "abnormally" early.

When he was not working, he would go to sleep about 2200-2300 and wake up "when the sun comes up." He had no problems falling asleep or staying asleep. He slept through the night and felt that the medications assisted with that while he had the flu. Prior to receiving the medications, he was not sleeping well on the prior trip because he was sick.

In 2006, he completed a sleep study and had a procedure performed to stop his snoring. That procedure was not successful and when he retired, he was offered a CPAP machine. He did not think he used it the night before the accident because he arrived late and wanted to go to bed, but could pull the report to verify.

On Monday, March 4, he woke up before his alarm. He slept well that night and thought he probably slept on the airplane up to Newark also. He had a passenger seat on that flight and was not in the jumpseat.

Prior to the accident, it was a normal day in the airplane. There were no anomalies and he and the captain even discussed that.

He had not met the captain before. She was formal and professional. They did not have an opportunity to talk about anything beyond flying before the accident. Captains usually took the first leg and he thought that was good practice. He had had captains offer him the first leg but it was usually by captains who he had flown with before. He was surprised when the captain offered to let him fly the first leg, particularly because they discussed the weather being bad. He thought she knew that he had flown to Presque Isle before.

The captain seemed alert on the accident flight. She did a standard briefing with the flight attendant; there was no glaring anomaly.

He had heard about her as a captain before the accident flight. It was typically for him to ask his friends if he had flown with a captain before that he was paired with. While captains usually had "glowing reviews", this captain was an exception; he had some prior information and some expectations before the flight. He did not feel comfortable discussing what he heard or his opinions.

He confirmed that they did turn the lights on at Presque Isle.

The captain called 122.8 about 10 minutes out to get the PPR. I did not recall monitoring the captain calling 122.6 to turn on the lights. He recalled telling her the correct frequencies for the approach and it was his recollection that she dialed it in and keyed the mic to turn the lights on. If he were turning the lights on, he would key the mic 7 times to get the maximum intensity. He did not know if the captain did that. He did not switch his radio but thought the captain switching the #2 radio to turn on the lights.

All of the sim training he received and subsequent LOFT after 6 months was at FlightSafety in Cincinnati. CommutAir dispatch was in North Olmsted, Ohio, collocated with their headquarters. He did not think there was always good communication with dispatch but on this flight they did. They called dispatch and discussed the weather before the flight. When flying to PQI, dispatch would give crews an updated weather condition via ACARS. He thought dispatch did a great job communicating and keeping he and the captain informed. Because PQI was an interesting airport to fly to with interesting conditions, he felt that everyone's level of attention was increased, and he believed that to be the case on the accident flight.

The Jeppesen charts would show information about special airports. The crew also had a company issued electronic flight bag (EFB). He did not think the FAA had given CommutAir the approval to get rid of the paper version of the approach plates so pilots carried those around also. For the accident flight, they briefed off the EFB iPad. Asked if they could use the iPad in flight, he said CommutAir crews were limited with what they could do with the iPad due to lack of FAA

approval; currently, they had to keep off the feature that would allow the GPS to locate you and georeference you on a taxiway. He complied with that rule.

In addition to readers, he had sunglasses with bifocals. Both were in his bag. At the time of the accident, he was wearing the sunglasses.

He believed they flew the localizer very well.

On his previous flight into PQI[1], it was a night VFR approach and they could see the airport "way out". He was the pilot monitoring. He did not think the captain was familiar with the airport so they discussed where it was and its proximity to Caribou Airport. The captain had pink needles on her side, and at some point he pushed the button to get the green needles. He noticed they were lined up perfectly but they had a 2 dot deflection on the green needles. He brought it up to the captain and asked if they should file an ASAP but the captain did not think so. He was not sure if the captain truly understood what he was relaying to her because she was flying the airplane. He left the problem alone and they continued flying the airplane all the way to the ground. He did not know what the deflection was as they got closer to the ground; they were farther out when they got the 2 dot deflection.

Regarding how the radios were set up, he thought they had CTAF and Boston Center on the #1 radio and 122.6 on the #2 radio.

The last runway condition update that he received showed the runway had a FICON of 3/3/3.

Asked if the crew thought about diverting, he said he and the captain had relative confidence that they could complete the second approach.

They had a false sense of security that they could see more than they could. They talked about the approach. The captain asked him if he was comfortable, said he said he was and they did it again.

The anomaly on his previous trip into PQI was not reported formally.

It was common to have conversations about NAVAIDs at airports.

He clarified that he was wearing his sunglasses with the bifocals at the time of the accident.

Regarding the crew's CRM, he said they were new together so they had not "gelled" yet. He thought they could have done better and it would improve over time as they flew together. General callouts were not as good as they could have been but he thought they did a better job at it during the second approach. Not doing good callouts resulted in the go around; the second time was more "by the book". But on the second approach, the information they were seeing was incorrect and they only had a second and a half to figure out what was right. The callout by the captain of what she saw and the ILS were both wrong.

[1] In an email dated March 22, 2022, the CommutAir party coordinator clarified that this was not referring to the accident flight.

He liked working for CommutAir. He did not have any concerns about working there and never felt pressured to take a flight that the did not feel comfortable taking.

There was always a lot of snow in the wintertime, but on the accident flight, it was a lot more snow at the airport to the point that he thought it was not the same place.

He felt the crew used more standardized call outs on the second approach.

He did not have anything else to add to the interview.

Interview: Maria Andrea Whitten, Captain, CommutAir
Date/Time: March 7, 2019, 1130 EST
Location: via telephone
Attendees: Marvin Frantz, Katherine Wilson – NTSB, Pat Hempen – FAA, Cory Hamernik – ALPA, Zachary Barrett – CommutAir

Representative: Neal Davis, ALPA Legal

In the interview, Captain Whitten stated the following:

She was 40 years old. She was a pilot for CommutAir since May of 2016. She was at CommutAir before, from 2013 through November of 2015. She left then came back. In the summer of 2017, she went from a Dash-8 (DH8A) position to the captain position. She had about 5000 hours total time, with about 1000 hours in the E145. She was typed in the E145, A320, and the DH8A. She had an ATP certificate. In the Dash-8, she was in the right seat. When she transitioned to the E145, she went to the left seat. She was based in Newark, New Jersey, and commuted from her home in Florence, Alabama, and also spent much of her time with her boyfriend in Atlanta, Georgia.

She had been a flight attendant for Omni from 2005-2008, flying on a DC-10 and B757. In 2008, she enrolled full-time in a flight training program at a 14 CFR part 141 flight school in Tulsa, Oklahoma, finishing all of her licenses in about 1 year, around March or April of 2009. There were no jobs and her mentor from Omni gave her guidance. She went to fly for Wilderness Air Charters, a charter company in Africa. She worked there from January of 2010 to January of 2011. She was basically a bush pilot in remote areas of southern Africa. She returned to the US, and from December of 2011 till October of 2012 she flew an Aero Commander 500 for Central Air Southwest, a part 135 operator. She flew night cargo 5 nights a week from Memphis, Tennessee, to Kansas City, Missouri. Then she went to Republic Airlines from October 2012 to January 2013. She had a couple of checkride failures there and was not successful passing all the training. She did pass her training for the Q400, but ended up leaving after she passed her checkride. She then went to CommutAir in March 2013. She was there till November 2015 flying as a first officer on the Dash 200 and 300 out of Dulles Airport. From November of 2015 through January of 2016, she was with Virgin America. Here she obtained a type rating on the Airbus 320. Because of some issues with her paperwork, she ended up leaving. Then she went back to CommutAir. She has been there since going back in May 2016. When she first went back to CommutAir, she flew the Dash-8 because she was still current on it. In the summer of 2017 she upgraded to the E145. She did have an unsatisfactory in her initial training due to learning some maneuvers in a new airplane but passed everything after that and had been successful in training since then.

She had some notes she had written, and she read them to describe the event. She had commuted from Atlanta into Newark on March 3, 2019, the night before the accident. She had had some changes in her schedule and had arrived in Newark between 2130 and 2200. She was originally scheduled to report at 0600 but then it was changed to 0830. She took the 0800 van to the airport the next morning for the flight from Newark to PQI. There had been some changes, and the paperwork was not ready. Dispatch said the paperwork was coming, and the weather was about ¾ miles visibility and 1100 ft. overcast at PQI, and runway conditions were 3/3/3, medium braking

action. She put the briefing on the speakerphone, so the FO got the briefing too. They agreed it was legal to go and dispatch would give an update enroute. She had been to PQI the week before. She had been there quite a few times. The weather now was a little bit worse than it had been before.

En route was normal. They got the ACARS with the latest weather. There was a NOTAM that you had to call PQI maintenance to make sure you had a landing clearance. Boston approach asked them if they had the NOTAM and they said they did. They started the descent to runway 01, the longest runway. Approach gave them CORAC at or above 3200 ft and they entered that into the FMS; they were cleared for the approach. She had already tried to contact PQI maintenance but was not able to reach them. She was finally able to reach PQI. They said to call three minutes out. They had switched to CTAF to make the calls. She called when they were three minutes out, and PQI said they were ok to land and had cleared the runway. They verified the localizer with the Morse code; it captured fine. The glideslope and localizer were smooth and gave no indication that anything was wrong. At 1000 ft., they were stable, and made the stable callout. She called 500, 400, and 200 ft. On the approach, she saw the lights but also saw a tower that looked very close; it felt unsafe. She said let's go around. They configured for climb, called Boston and dispatch, and ran the checklist. Boston asked if they were doing the published missed. She said yes we can. They were on "green needles" and called PQI maintenance to let them know they had not landed. They said ok to a second attempt.

They were IMC, so she asked Boston for vectors for runway 1. They got re-set up for the approach and debriefed the first approach. They had ground contact on the first approach. The FO said maybe I looked out too soon. She said she had had this happen before, and he had to keep his eyes inside the airplane until she called missed or runway in sight. She asked the FO if he was comfortable doing the second approach. She told him she could do it if he wanted her to. He said he was ok to fly the second approach and he thought he knew what had happened. She did not have any issues with him flying the approach again; she did not feel threatened. The second time the capture was normal. They were stable at 1000 ft and began counting down at 500 ft. She told the FO the autopilot should come off at 200 ft. They would then decide if they had to go around again. The had an alternate (BTV) and plenty of fuel. She saw lights before they descended to minimums and called "lights in sight." She saw the same tower again and said, "watch out for that tower." At 200 ft. the autopilot came off. They still could see the approach lights and MALSRs. She said, "runway in sight at 12 o'clock." They continued to descend. Once everything was visual, she could see the runway. The localizer and glideslope were centered. She could see the trees on the side, and she said, "runway in sight." As they were flaring, all of a sudden it was like they hit something. It came very quickly. She said "WTF was that". Then it was just like a blanket came out of nowhere. Everything was white, we expected the snow. She remembered bouncing a few times up and down. She saw the FO going back and forth, so she grabbed the throttles and brought them back to idle. When they stopped, she looked at him, and there was a lot blood on his side. She did not know how bad he was hurt, so her initial reaction was to go ahead and shut-down the engines. She brought the fire handles down, then thought of the passengers. There had been no brace command, no expectation of anything. She thought she had to make an announcement for the passengers to remain seated. She thought about a fire, but there was no indication of one. She remembered hearing the landing gear warning. She looked at the gear handle and saw it was down. She finished the shutdown and wanted to make an announcement, but her headset was off, and she

could not find the hand mic. It took a minute for her to get out of her seat. Finally, when she was able to open the flight deck door, she saw the flight attendant and she was very calm. The captain asked if she was ok and if the passengers were ok. The flight attendant said yes. She told the flight attendant they were going to evacuate but to hold off a minute. The captain tried to call PQI maintenance (on CTAF) and Boston, but there was no answer. She grabbed the QRH and looked at the evacuation checklist on the back page. She remembered shutting down everything. Then she looked at the FO who was bleeding but talking back to her; she never saw him go unconscious. She checked on the passengers but didn't open the door yet. She walked through the cabin checking on the passengers. Every passenger she talked to was conscious. She went to the back seat. Some passengers said, "we're fine." There was lots of snow outside. She did not feel it was safe to evacuate yet. She went back to the cockpit and turned the batteries on to call PQI to say they were going to be evacuating. They finally answered, then she turned the batteries back off. She saw some firefighters and a snow plow approaching. They evacuated the FO first, then two passengers who seemed hurt, a lady who was having back problems and a lady with a big bump. On the way to the terminal in the bus, everything was white. She could not distinguish where the taxiway was. She could see very far. She could see the trees on the other side. The visibility was pretty decent. She remembered taking a video.

On the first approach, she was expecting to see the MALSR lights. The lights she saw were white. As they were coming around after the first approach, she remembered telling PQI maintenance to please turn the lights on bright, and they said they would be on bright. There was no PAPI or VASI, just MALSR. During the missed approach, the stick-shaker went off. She was not expecting the tower; they quickly did a go-around to dodge the tower to the left. It was a reaction to avoid the tower. They did get a "do not sink" message as they leveled off after the go-around. She had planned to write a report on what happened.

She had flown into PQI a few times. It was a different runway environment than during her previous times into PQI; she did not remember it being this way. Some pilots wanted to avoid PQI. Poor communications was the reason. The paperwork and weight and balance had to be done manually (not on the FMS) because no communications were available; it was a remote area and reception was not good.

She thought this was the first time she had flown with the FO. She asked him if he wanted to fly the first leg or her; she liked to give people the choice He said he's got it. Even when someone was new, she assumed they were well trained, and she did not feel threatened by that. He mentioned that he had been to PQI before. She had also been there a few times. The weather had not been this bad previously.

In her previous flying (cargo) she got training in weather, deicing. She was flying single pilot in an Aero Commander. She used to fly into Cleveland Lakefront airport and in Michigan, and she had experienced some really bad snowy days. She did experience snow conditions at CommutAir but did not recall receiving any specific training from them on illusions when flying into snowy conditions.

Either pilot could call for a go-around. At minimums, calls were "lights" if they were seen. If seen, then you can go 100 feet lower, (which they did) but autopilot had to be off. She could not state

exactly what the manual said the callouts should be. Next would be "approach lights in sight-continuing." Then the PF should look outside when "runway in sight" is heard.

She remembered on the second approach the tower was there again. It was the same feeling as before. It was right in front of the approach to runway one. She told the FO "watch out." He leveled off to clear it, then continued down. Everything was still in sight.

The crew got drug and alcohol screening at the hospital.

The FO said something when they left the airport. He said the last time he was there, the runway was on the left. He did not have any issues landing that time. She said we'll see if the localizer is offset or something like that. She did not see anything that indicated that.

She had worked the night shift the week before, so she commuted in the night before because of that; she had been home for 2 days. The night before the accident, she got to the hotel around 2200 and went to bed around 2330; after arriving in Newark she had to wait at the airport to confirm where she was staying that night. She set the alarm for 0700 and took the 0800 van. She had an 0830 show time. Coffee and a power bar were her usual breakfast. She slept well that night and had no problems falling asleep or staying asleep; she felt great when she woke up Monday. She and the FO had normal chitchat on the way to the airport.

On Sunday, she woke up around 7 or so to go to church so she thought she had gone to bed the night before about 2300.

On Friday, March 1, she was working, and her report time was 1115. She flew three legs and finished in Newark at 2044. Then she went to Atlanta and got home around midnight. On Saturday, March 2nd, she was pretty tired from the night before and could not recall when she woke up. She only left her house for dinner that night, and went to bed a little earlier, maybe around 2300 or so.

She had no sleep disorders or sleep issues and did not use tobacco. She used alcohol sometimes. Her last use before the day of the accident was one beer sometime the week prior with her FO on a long layover. She had a first class medical with no limitations; she did not wear glasses. She had no hearing issues and took no prescription medications, just vitamins. In the 72 hours prior to the accident, she had taken Tylenol and used a nose spray on Friday night, but no other prescription or nonprescription medications.

She had no previous accidents or incidents and had not received any commendations for her performance.

At Republic, she initially failed then passed her checkride. She left the company due to LOFT issues. Republic put it in her file that she had failed her training. She thought she had resigned. She did not feel that she got proper training and decided to leave.

She had no issues or concerns flying with the FO. This was the first flight of the day; they had to deice prior to leaving Newark. She tried to instill good CRM among the crew. She had no problems with the flight attendant either. Regarding the CRM with the FO, she had not had any issues. She

tried to verbally set the tone for CRM. She encouraged the crew to speak up as needed if he saw something he did not like. She had "an open-door policy."

The FO seemed fine. He was coughing, but otherwise no major issues.

On the first approach, everything seemed fine until the tower appeared, then she said go-around. She had some ground contact on the descent. Before the tower, she saw the lights and they seemed to be correct. She was expecting a MALSR and started looking for it. Before the tower, she had made the call lights in sight. The tower stopped her from looking for the runway. When she saw the tower, she said something like watch out or don't hit that or go around; go-around was the main concern.

The autopilot was on for the first approach. She could not recall where FO brought the autopilot off. On the second approach, everything seemed fine. She was more focused due to the previous missed. Everything looked mostly the same until around the flare. Glideslope and localizer looked fine. There was no indication that anything was wrong. She could see the runway. It was VMC. She could see outside. They hit something just before touchdown, maybe around the threshold, in the flare, and she said, "What is that?" She did not remember anything different in the lights on the second approach. She did see the tower on the second approach. The FO levelled off a little bit. They were transitioning at that point. They had ground contact. The tower was not the thing they hit. They went over it and the lights were still there. She thought the tower needed to be removed. On the second approach, at minimums, she had already seen the lights. She called "approach lights in sight" so they continued another 100 feet, then the runway was in sight. Localizer and glide slope were lined up, both times. Everything seemed ok. She saw the MALSR. She saw the tower toward the right front of the airplane. The tower was a big pole with a red light on top. The pole was dark. It was right there. It did not feel safe. At that point, they were already coming down.

On the second approach, she did not key the radio on 122.6 for the lights. She did this on the first approach. She thought she keyed the microphone 5 or 6 times to bring the lights on. The second time, the airport had said the lights were on bright. The (field condition report) 333 came from dispatch. The airport did not normally give them any weather. They had never given her any weather. She had not noticed any issues at PQI when she had been there before.

She was not wearing sunglasses during the approach. She had flown into PQI a week prior. This time, there was more snow. Everything was white. She had received an update of field conditions while en route to PQI. They were still 3-3-3. She did not remember getting any updated conditions from PQI. On both approaches, she thought the lights were white. Everything was white on the ground. The lights, localizer, and glideslope were what was expected. There was no pressure to conduct the second approach as opposed to diverting to their alternate. She had 122.8 and Boston Center on the radios. There was no CDI deviation on the approach.

She couldn't recall the cruising altitude to PQI; the flight was about an hour or so. Boston gave them the altimeter setting for PQI. She put it on the standby altimeter to help her remember. She remembered briefing on the way back around after the go-around. She did not remember the altimeter setting. She remembered a single light, then a line of three lights, like vertical lights. That

was when she called approach lights in sight. She saw a red light. It stuck out, more towards the right of the front of the aircraft. The row of white lights she saw were in front of the aircraft. Once she transitioned to where they could see the runway, she remembered seeing the threshold light and the trees from far away. On the second approach, when she called the approach lights in sight, the FO had already turned off the autopilot. They went down another 100 feet, and that's when she saw the threshold, and called runway in sight. She was looking in and out. The airplane had made the minimums call after she called approach lights in sight. She did not make a minimums call. En-route, she expected the runway to be white, not full of gray concrete. She thought she wasn't thinking about what the surface would be like, either a patchy, partially covered surface or not.

She thought the FO switched from pink to green needles (FMS to NAV) right before they reached CORAC. She thought later she switched to green needles. She could not recall if she noticed any discrepancies between pink and green needles. On the localizer, when they were relatively far out, the airplane did not do any of the "ERJ homing around", it was pretty steady, with no bouncing or wobbling on the approach. They had no issues with the airplane.

The interview ended at 1320.

Interview: David Walter Fitzgerald, Vice President Flight Operations, CommutAir
Date/Time: May 20, 2019, 1030 EDT
Location: CommutAir offices, North Olmsted, Ohio
Attendees: Marvin Frantz, Katherine Wilson – NTSB; Nicholas Biondo – ALPA; Zack Barrett-CommutAir

Representative: Mr. Fitzgerald declined representation.

During the interview, Captain Fitzgerald stated the following:

He had been the Vice President of Flight Operations since July 2018. From August of 2016 until November of 2018, he had held the position of Chief Pilot; there was an overlap in his previous and current positions of about 4 months while the company hired a new 119 chief pilot.

He held an ATP certificate with B-1900, E-145, and CL-65 type ratings, and had about 12,500 hours of total flight experience. He started with CommutAir in November of 2015 when he was hired as chief pilot. Because of regulatory requirements, he could not assume that position until August of 2016 when they began operating turbojet aircraft (the E-145). Until that time, his title was "incoming chief pilot".

He learned about the accident from a level 3 notification from the company and from the chief operating officer (COO).

Asked if a pilot had a localizer problem how the crew would report it, he said he would expect a pilot to go through the reporting system even if he or she was unsure if it should be reported. Pilots were told to file it as an ASAP report and, if more appropriate, as an incident report. But pilots were encouraged to make safety reports either through ASAP or Incident reports. Assuming a pilot did nothing wrong, he would file it as an incident report.

Prior to the accident, he was not aware of any reports about PQI. There were specialized reports in WBAT like issues with ground power carts at stations. The company also had a hotline that pilots could use to report a concern anonymously. He clarified that pilots were told it would be best to submit an incident report 95% of the time.

He knew of PQI concerns about field condition reporting and pilots were encouraged to submit an incident report. At the beginning of operations to PQI, they had communicated issues to pilots on the 10-7 chart.

Incident reports were reviewed every Monday during the Safety Committee meetings, then escalated up to other levels as needed. If needed, information could be conveyed to pilots by placing a note in the dispatch release "daily read" section which pilots were required to review prior to each flight. They could then ask pilots to give them feedback on improvements or tell them not to use the ground equipment. If necessary, information could be passed on to their POI or an ATC center to get that information to the airport. He could not recall a specific event where they had to do that in the past.

CommutAir used the FlightSafety facility but their own instructors for training. They had exclusive use of two simulators. He thought it was best to ask the director of training about if and how whiteout conditions were covered in training but said simulator training included flying down to minimums then missed approach procedures if the runway was not in sight.

CommutAir started flying into PQI in the summer of 2018. He thought they had put out a crew memo for PQI. Memos were usually administrative in nature, a flight operations information letter covered a specific item in depth, and a training bulletin talked about changes to training or procedures.

At PQI, runway lights were triggered by a different frequency than CTAF, so it set off red flags for him when they were going to fly there and he made it clear to pilots so they understood that nuance when operating into there. There was no special training for PQI.

As the vice president of flight operations, he said safety was there highest priority; his duties and responsibilities included administering flight operations, overseeing operations and training, airport operations and the inflight group. He reported to the COO.

When he was Chief Pilot, his duties were to ensure safety was their highest priority and be the direct supervisor for the line pilots. He had reported to the DO/Vice President of Flight Operations; he clarified that when he was the chief pilot and was also the vice president of operations that he did not report to himself.

Flight Operations representative attended the weekly Safety meeting.

He currently flew for the airline about 5-10 hours per month; there was no required minimum number of hours he had to fly. He had flown into PQI in the winter long ago, with a former employer in a Beech 1900.

CommutAir had a preferential bidding system that allowed pilots to select another pilot by employee number that they did not want to be paired with. He did not regularly monitor this but they could look at it in specific circumstances. He did not know if this had been looked at for the accident captain.

He was aware that the captain had to retrain after her first upgrade attempt. He had no knowledge of any problems with the accident FO.

Failing a checkride was not common, but not unheard of. If an airline had no failures at all, it would indicate that something might not be right.

Since the accident, he became aware of localizer problems at PQI that were reported before the accident.

Reports were reviewed by the Safety Committee at a meeting every Monday and had to be submitted by the Thursday before the meeting. If needed, a corrective action record was generated and distributed appropriately.

A FOQA newsletter was distributed to the pilots, maybe quarterly, but he was not sure. He received regular updates from the FOQA Manager.

He knew the accident captain and FO by name. He had had interactions with the captain. He had heard concerns about the captain, not from the flying standpoint, but rather interpersonal issues. He thought the action he had taken against her in the past had yielded the intended result. She received a disciplinary letter when she was an FO on the Dash-8; it was an agreement with her to forgo upgrade to captain and be monitored for nine months.
(He also stated he had put a disciplinary letter in the captains file as part of this action)

He had not flown with the accident captain. He was not sure but did not think he had flown with the FO.

A captain once had reported almost non-existent braking at PQI when the airport had put out a FICON (field conditions) report of 5/5/5 which was better than "close to nil". They worked with the station and airport operations group to make sure reporting was accurate to the conditions at the time of arrival.

It was a collective bargaining agreement; the captain did not fail training but rather failed a checkride, was retrained and passed the next time.

He was not employed by CommutAir when the captain was at the airline the first time. He had no knowledge of any issues with the captain during her first period of employment at CommutAir. He thought she came back to CommutAir after she did not make it through training at another carrier. The decision to rehire her was done by the flight operations management group which included him and the chief pilot. She was eligible for rehire and he was not aware of any issues in rehiring her. He removed himself from the decision because he did not know her prior.

HR made PRIA requests for new hires who would then compile the application that would be reviewed by a pilot working in recruiting then the flight operations manager. He thought PRIA requests were made both times the captain was hired by CommutAir. If he looked at her PRIA records, he could not recall any red flags. He believed he had reviewed both the captain and the FO's employee files since the accident which would have included PRIA records.

Besides the delayed upgrade, he knew of no other discipline or counselling contacts with the captain while he was chief pilot; there were no interactions that caused him concern. He was unsure of training issues prior to when he came on as the chief pilot. A union representative had indicated in conversation that there were issues with the captain during her first period of employment at CommutAir prior to her disciplinary hearing in 2016. He had heard this verbally, there was no context and he did not know any details.

The interview ended at 1145.

Interview: John "Chip" Dettra, Chief Pilot, CommutAir
Date/Time: May 20, 2019, 1245 EDT
Location: CommutAir Headquarters, North Olmsted, OH
Attendees: Marvin Frantz, Katherine Wilson – NTSB, Zachary Barrett – CommutAir, Nicholas Biondo – ALPA, Eric West – FAA

Representative: David Fitzgerald, VP of Flight Operations, CommutAir

During the interview, Mr. Dettra stated the following:

He was the 119 Chief Pilot for CommutAir. His date of hire was November 28, 2018, and he held no other positions at the company. Prior to being hired by CommutAir, he worked at Trans States Airlines as the East Coast Regional Chief Pilot for 6 years. He held an ATP certificate and ratings on the EMB110, 120 and 145, CRJ200, Jetstream BA3100, and Metroliner SA227. His total time was about 19,600 hours, most of which was as PIC.

Prior to the accident he had heard that PQI was a difficult airport to work with. He did not know any specifics of incidents that had occurred there prior to the accident. After the accident, he learned about obstacles such as weather forecasting and airport conditions. He also heard about issues with the localizer but did not know anything directly about that, just that there was a general discussion about it; he inferred from people he heard talking that there was a localizer issue at PQI.

If a pilot knew about a localizer issue at an airport, he would expect the pilot to report it via ASAP as a good starting point because it related to safety of flight. If it was not flight related, he would ask the pilot to submit an incident report. He did not receive ASAP reports but had access to incident reports that were completed via WBAT. He did not get a notification when incident reports were submitted but it was a part of his process to look at the reports; he tried to do this daily. If he knew about an issue that should have been reported but was not, he might go to that pilot and remind them to file a report.

He clarified that he was not aware of any issues with the localizer at PQI prior to the accident.

He was not at all familiar with the captain's records from when she previously worked at CommutAir. He had met the captain once prior to the accident when he was introducing himself to pilots on the line after he was hired. He had not heard anything about the captain.

He clarified that PQI was difficult because of the reporting of field conditions.

Since the accident, he did not look at the flight crew's records. He did not know the FO.

He thought pilots were very comfortable reporting safety concerns. It was a simple process and CommutAir made it as easy as possible to report using the pilot's iPad. ASAP reports were required to be filed within 24 hours. They encouraged pilots to report an issue as soon as possible.

Asked what he thought it meant that pilots did not report issues with the PQI localizer until after the event, he thought it meant they needed to get information out to crews about reporting incidents. He did not think it was a safety culture issue but that maybe some pilots were new in terms of using that system.

He reported to the director of operations. As the chief pilot, his duties and responsibilities were the day to day operations of the pilots. He did not do much work outside of the pilot group but at times would interact with maintenance because the pilot group talked to maintenance.

He went to all safety meetings. If he could not attend in person, he would call in. He also attended the flight operations meeting. And received emails on safety concerns.

He did not have any direct interaction with FOQA data. He might get some information on a specific area and then would work with the FOQA group on that.

Depending on how quickly the information needed to get to crews, they could share safety information through notes in the dispatch release, with a crew memo or by developing training. Crew memos were available online and the pilot would log in to view it. The information could also be sent via email to the pilots. He knew that online training received was tracked but he was not sure if they tracked when crews read a memo. The company's electronic flight bag (EFB) was still in the certification stage. (Mr. Dettra's representative added that when a crew memo was opened/read on the EFB, that was tracked by the company).

Mr. Dettra did not currently fly but he did ride in the jumpseat for 3-4 legs per month.
The pilots applying for jobs had broad experiences. If a pilot was coming from another company, his concern would be why they were leaving to come to CommutAir. He knew that pilots with a military background could be trained but his concern would be that they might not have fixed wing experience and so how do they adequately train them. The pilots with the least experience would typically be flight instructors and for them his focus would be their trainability and enthusiasm. Since he started at the company, he had been involved in the hiring process of new pilots; he sat in on interviews and also attended social events.

CommutAir's training center was near Washington, DC. He would go to indoc training and sit with new hires in the class; he would also sit in on systems training and upgrade training.

CommutAir had a captain entry program but it was increasingly more difficult to find captain qualified new hires.

In addition to the reporting systems, safety concerns could be reported directly to him which pilots did do. Those issues were usually things requiring immediate attention like a ramp issue. Pilots could also send him an email.

Regarding anonymous reporting, he thought ASAP could be considered anonymous because the reports would be deidentified.

He clarified that it was after the accident that he heard pilots talking about issues flying into PQI.

Regarding winter operations at PQI, he knew there were issues with weather reporting such as the timeliness of its reporting. He was not aware of runway lighting at PQI or the frequency for controlling the runway lighting.

He had not listened to the UNICOM recordings of the accident flight.

He was not a check airman.

He thought the CMO's office was in North Olmsted and the POI was John Machemer. (Mr. Dettra's representative clarified that the CMOs office was in Albany.)

He did not pull up flight releases at random, so he did not know of any particular information being included about PQI on the dispatch release. The "daily read" was an attachment to the dispatch release; the release was printed for pilots.

He had not flown the line yet at CommutAir.

He had not had any concerns reported to him about the captain. He was not aware of any training issues by the captain; he clarified that there were a lot of pilots to get to know in the short period of time since he was hired. He did have access to pilot training records.

He clarified that he did not look at the crew's records since the accident. He had not reviewed any PRIA information the airline may have received about the captain.

He heard about the accident via an email from the SOC. He tried to gather more information about the event and had a very brief conversation with the captain while they were in transport to the terminal. The phone call with the captain ended when the cell signal dropped and the call disconnected. He only talked to the captain and not the FO.

Asked if he had anything to add to the interview, he clarified that his focus was on the "immediate and present forward" needs of the pilot group. There was a great team at the company that handled the issues following an event. That group would look at past operations and then would guide him if some action was needed on his part.

The interview ended at 1335.

Interview: Jeffrey Sean Harris, Director of Flight Operations Training, CommutAir
Date/Time: May 20, 2019, 1355 EDT
Location: CommutAir Headquarters, North Olmsted, OH
Attendees: Marvin Frantz, Katherine Wilson – NTSB, Zachary Barrett – CommutAir, Nicholas Biondo – ALPA, Eric West – FAA

Representative: David Fitzgerald, VP of Flight Operations, CommutAir

During the interview, Mr. Harris stated the following:

He had been the director of flight operations training since July 2017. He held no other positions at CommutAir. His duties and responsibilities included overseeing pilot training and supervising instructors and new hires in training.

He had a Part 121 background and previously worked at Horizon Air, Empire Air, and Allegiant. He then worked at FlightSafety as an instructor, program director and director of training just before being hired at CommutAir.

He held an ATP, airplane MEL, commercial SEL, CFI (expired), AGI, MEI and CFII certificates and ratings on the ATR42/72, Challenger 600 and Citation 500. He had about 8,000 hours total time.

He did not fly at CommutAir or do jumpseat observations.

He reported to the director of operations. He had 40 instructors, ground training manager, and flight training manager who reported to him. Some instructors were full time instructors but not line qualified; others were line qualified. Line check airman did not fall under his purview; they reported to the manager of standards.

CommutAir did not train under AQP. They used in house instructors in FlightSafety devices.

New hires received 40 hours of indoc, 126 hours of systems and GOS (general operating subjects), and 30 hours of system integration. After that, they would go to FlightSafety for 3 days of GFS (graphic flight simulation) where they did flows and callouts, followed by 10 simulator sessions, a checkride and LOFT. The initial equipment training followed the same footprint minus the indoc portion. Upgrade training was 44 hours in the classroom, training in the simulator without motion, 7 simulator sessions, a checkride and LOFT. Pilots also received 26 hours of ground school in recurrent training, and an annual LOFT and proficiency check; this was for both captains and FOs. During recurrent, captains and FOs were paired for simulator sessions but in initial training it could be FO/FO or captain/captain pairings.

LOFT scenarios were determined by issues identified on the line over the past year using FOQA data; LOFT was updated annually. Instructors could choose from 5 scenarios. Scenarios during the previous year's training focused on pilots' comfort level when the FMS or autopilot were inoperative; other issues used in LOFT focused on bleed overheat issues or pack failures.

There was not training on white out conditions but they did train for winter weather. Winter weather operations was covered in initial ground school; recurrent training included CBT training and a simulator scenario such as deice procedures.

There was no special training for flying into PQI. If necessary, there were special use airports where pilots would have to review charts before operating there or other airports, like DCA, had online training.

Training included crew resource management (CRM). It had been revised in the last two years and starting June 1 it would include flight attendants. Pilots received roughly 10 hours of CRM training during initial training. He could not recall the topics covered.

The number of missed approaches flown in the simulator was "significant" and the specific scenarios flown were outlined in the sim instructor's guide. They were currently updated the guide and had updated 5 of the 10 scenarios so far.

He only knew the accident crew by name. He reviewed their training records the day of the accident and nothing stood out as significant.

If a pilot did not pass a checkride they would look at the totality of why, was it one issue or multiple issues. It would be reviewed by the training review board (TRB). There were precursors that would prevent a pilot from moving forward. Any failure or failure to progress required a review. There were changes to the regulations recently and they integrated their remedial training with the TRB as a part of that change. Outcomes could be an extra simulator session or additional IOE.

If a pilot was having interpersonal issues, he might coordinate additional CRM training; the request usually came from the chief pilot and he would coordinate scheduling of that training.

If a pilot got the stick shaker during a missed approach, it would be a heavy debrief item; if the pilot did not do the appropriate stall recovery technique, they might due a flight freeze.

The TRB included himself, the director of operations and an ALPA representative.

Instructors were not required to make notes unless they gave a grade of 3 which meant additional training was required. The instructor would also have to give an objective statement as to why that grade was given. Instructor notes were kept as a part of PRIA.

He was involved in the PRIA review only if the PRIA was questionable and then it was a flight operations management review.

He signed the captain's training record when she went through upgrade. After the accident, he heard "water cooler talk" about her previous experience. He was the director of training when she completed upgrade training. He believed she had a failure but said it would depend on the failure whether her case was reviewed by the TRB. Other than that, she had not come to his attention. He only heard rumors about her not completing training at another airline.

He clarified that "increased scrutiny" on a pilot's training records meant that pilot was in remedial training and tracking. The GOM listed the items that had to happen for a pilot to be on the increased scrutiny list. If a pilot completed ground school or a line check as a part of the increased scrutiny program, that did not count towards the annual requirement for ground school and a line check. If a pilot entered the increased scrutiny program, the crew member records group would add them and maintain the list. He thought items listed in the GOM included a failed checkride, more than 25 hours of OE and having to complete additional simulator sessions. The GOM listed the items to enter the program and what a pilot had to do as a part of the program. An "Increased Scrutiny" stamp was placed on the training item in the pilot's training file that needed to be accomplished for the pilot to get off the increased scrutiny list.

Instructors could voice concerns about someone in training by email (training@commutair.com) or by coming to him directly. It was stated in the pilot training manual that when a pilot received a grade of 3, the instructor must email him about why the training item was given that grade. He did not recall any discussion about the captain's training.

He reviewed the captain's files after accident. He also reviewed the FO's files and there was nothing to his knowledge of concern.

He could not speak directly to what was included in training regarding reporting of safety concerns. The safety and SMS manager would conduct the training via live conference during initial, upgrade and recurrent training; they owned that part of training.

He thought the reporting culture at CommutAir was a work in progress. The accident at PQI was the "perfect example" of crews not reporting an issue to the company, but only to the FAA. That brought up the question "why". He thought they did a good job of providing information and encouraging pilots to report through any means but he did not think people were using it and he did not know why. It was a work in progress to continue sharing the message that they want pilots to report information. They would rather have too much information than not enough.

He was not on the ASAP ERC but did see ASAP and incident reports. He would get emails when a report was submitted through WBAT. He would also go into the system multiple times a week and review both incident and ASAP reports. The safety department would also send out relevant reports to the flight operations distribution list.

If a pilot came to him with a concern about a localizer issue at an airport, he would tell the pilot to fill out an incident report and he would also take that information to the director of operations or the safety department. He had never had to do that but was confident in their flight operations management team to get the information to the right people.

He could not think of anything that would disincentivize a pilot to report a safety concern.

The TRB process varied by individual check ride failure. Prior to March 12, it was not a defined process; sometimes the review would be as simple as an email or other times was a meeting with multiple people reviewing it. After March 12, they now specify when the TRB will convene, how

information is documented, etc. He did not recall a TRB for the accident pilots. Before March 12, the process was strictly contractual. Only TRB information was on the remedial training form.

CRM training during initial new hire and new equipment training was about 10 hours, but at least 8 hours. CRM was also provided in upgrade and recurrent training but for less time.

There was no specific training for flying to PQI. There were detailed 10-7 pages that provided pilots with more information on an airport. There had been multiple emails and daily reads about PQI but he could not recall if these were before or after the accident. (Mr. Harris' representative added that there was a crew memo prior to operating into PQI about how to operate the lights.)

He had not listened to UNICOM of the accident flight.

PRIA was generally handled by the chief pilot and HR recruiting offices.

They trained that in low weather, both pilots had to be in agreement to land.

He could not recall having to elevate a safety concern reported to him but said it was a very collaborative environment. He recalled lots of discussions when flying into DCA. The company met with the ALPA safety team to minimize the safety risk.

A pilot would be removed from the increased scrutiny list after one year if the required items from the list in the GOM were completed.

CommutAir had about an 18% washout rate in 2018, a majority of which was from initial training. There were few in upgrade training.

Since the accident, there had been discussions about things they would like to see to make things better like a captain monitored approach when weather was below 4000 feet RVR and how to make the reporting culture more robust.

The training department did not have a role in the accident investigation process. He was notified about the accident when someone came by and asked if he had heard about it. Although not his role, he was asked to secure the pilots' training records but when he got to the records department the records were already secured.

He clarified that a captain monitored approach meant that the FO would be heads down the whole time and the captain was looking out the window. The FO would fly down to minimums and fly the missed approach or the captain would take the controls if the runway environment was in sight; the change of controls would be when the runway was in sight.

He was not typed in the EMB145 so he could not talk to the specific callouts pilots should make.

They did not have approval to fly CAT II approaches but had requested it.

He was not aware of other reports of low altitude navigational issues.

They used to train for CAT II approaches even though they were not approved to fly them but they had stopped training for that.

Winter operations training was yearly and it was developed by the training department in conjunction with flight operations. It was updated yearly because the FAA would make changes to things like holdover times. Topics covered included operating in a winter environment, deicing procedures, how to read hold over tables, deice fluid, what they can operate in or not, and runway conditions; TALPA (takeoff and landing performance assessment) would be included next year.

They had not talked about winter weather operations in relation to this accident. The winter weather operations training usually rolled out in late October or November.

Training covered spatial disorientation but in was in relation to upset and recovery at altitude. Asked if CommutAir trained pilots for spatial disorientation, featureless terrain illusion or whiteout conditions, he said he could not say specifically but thought they did. There was ground school for upset training going on now and there would a simulator session for pilots later this year. They talked about spatial disorientation in upset and recovery at altitude but was not sure of other training that covered that.

He had nothing to add to the interview.

The interview ended at 1452.

Interview: John F Darke, Managing Director of Safety, CommutAir
Date/Time: May 20, 2019, 1510 EDT
Location: CommutAir Headquarters, North Olmstead, OH
Attendees: Marvin Frantz, Katherine Wilson – NTSB, Zachary Barrett – CommutAir, Nicholas Biondo – ALPA, Eric West – FAA

Representative: David Fitzgerald, Vice President of Operations, CommutAir

During the interview, Mr. Darke stated the following:

He had been the managing director since 2018 and prior to that was the director of safety since 2012. He was hired by CommutAir in 2007 as a Dash-8 pilot, then worked as the manager of regulatory compliance, assistant director of safety and a ground instructor on the Dash-8.

Prior to CommutAir he got his pilot ratings on his own and worked full time as a flight instructor and part time doing corporate flying. He had about 3500-4000 hours of total flight time. He no longer flew for CommutAir.

In his current position he reported to the chief operating officer. His duties and responsibilities included being in charge of the safety programs for the airline including ASAP, FOQA, fatigue, environmental health and safety, IEP (internal evaluation program), emergency response, regulatory compliance and SMS. Staff that reported to him included the safety program manager, manager of regulatory compliance, IEP manager, manager of SMS, two IEP auditors, FOQA manager, environmental health and safety manager, a part time safety specialist and they were hiring a FOQA analyst to do the day to day processing work.

Reporting programs included ASAP, incident reporting, and fatigue reporting through WBAT, a safety hotline, safety and concerns suggestion box, email and direct reporting to him. He thought they received 109 pilot ASAP reports in a recent month which was an all time high. They also got over 700 pilot ASAP reports each year and over 400 pilot incident reports. They also had ASAP for flight attendants, dispatchers and mechanics.

CommutAir had a fatigue risk management program for pilots and the flight attendants were being added soon. The fatigue management committee was made up of representatives from the company and ALPA. All reports were reviewed by the committee who would determine the root cause, classify the reports, and follow the process for reporting.

He described the safety culture at CommutAir as "good" and said they worked well with ALPA; they had an open relationship with the company and ALPA.

He thought pilots "absolutely" felt comfortable reporting safety concerns. Asked how he measured this, he said it was perhaps because he was previously the ASAP manager and his dealings with ERC where he saw what was reported. They had a high number of ASAP reports submitted last year and most of them were sole source reporting. They were worried about the program about 6-

8 months ago when the FAA ERC representative did not agree to accept an event to ASAP. They worried that would damage the reporting culture but he did not think it had an impact.

When an incident report was filed, all managers would receive an email with the report narrative. This email was sent regardless of the time of day. If it was a pilot submitted report, for example, the flight operations group could deal with it immediately. In addition, all incident reports were reviewed weekly by the committee which consisted of members from the company and ALPA. The committee would risk rate the reports and determine if it needed to be escalated to the safety action group and attempt to resolve any issues raised from the report.

FOQA data were continuously monitored and all airplanes' data were captured. They did not add a new airplane one by one but would wait until they had 4-5 new airplanes and all of those would be added to the FOQA program together. The data was downloaded every 2 weeks at the service check; he thought this might be every 100 hours. The data would be downloaded from the MFDAU (miscellaneous flight data acquisition unit) then uploaded to the General Electric site then processed through FOQA. The FOQA manager would look at the data and process the events from each aircraft. The FOQA manager resigned at the beginning of May 2019 so they planned to hire an analyst to look at the data and would move the management duties under regulatory compliance. The FOQA manager would determine what to do with the data and who to push it out to while the FOQA analyst will "crunch the numbers."

He was not aware of any concerns about the localizer at PQI before the accident; he thought there were 4-5 reports filed after the accident. He was not sure whether pilots did not recognize the importance of what they had seen or did not know it was something that needed to be reported. Since the accident, navigational aid discrepancies are a mandatory reporting item.

They were launching an awareness campaign "see something, say something" and there was an easier way to report under this program. They had been doing safety awareness trips to the bases and crew rooms, at least one base per month, talking to the flight attendants, pilots, and mechanics. They wanted to make reporting easier and bring a greater awareness to its importance.

He learned about the accident when he got a text message from the safety manager at United who asked if they were activating their emergency response plan. He then found out from the CommutAir SOC (systems operations control) who had been on the phone with the pilots. The PQI station personnel had called United's NOC (network operations center) but did not call CommutAir's SOC.

United Express had a managing director of safety; he interacted with the managing director and her team. Aside from United Express providing support that CommutAir needed, they also had quarterly safety meetings with the United Express safety leadership team.

CommutAir provided data to United such as turbulence injury data, aircraft damage data, and frequently United would request data on hot topics or top hazards. If an aircraft received any ground damage, the investigation was usually handled by United if it was their staff that was involved.

CommutAir's SMS program was accepted in December 2018.

The safety department provided initial and recurrent training that focused on SMS, employee reporting, and environmental health and safety.

There had been a lot of discussions since the accident. They were doing everything they could to increase the safety reporting and culture. He thought it was good but they could always be better. He thought pilots did not recognize they needed to report the localizer issues and they needed to come up with the perfect examples to show how reporting an issue can help safety or how something that was not reported hindered safety.

He did not know if the pilots had reported concerns about the localizer whether that would have prevented the accident. However, if they had known, they could have turned the aircraft around. When they operate into an uncontrolled field, they were the last line of defense; if it had been reported, the company would have reacted to it.

The employee group of the person who submitted would know right away and the email would include a link where the employee group could get more information beyond the narrative sent immediately in the email.

They tried to have monthly ERC meetings. The ERC would receive an email immediately when an ASAP report was submitted. If an issue submitted to ASAP was an emergency, someone from the ERC would have to report it.

If a pilot submitted an incident report but after review he felt the pilot should submit an ASAP, he might call the pilot and tell him. If a pilot submitted an ASAP report that should have been an incident report, he would let the ERC make the decision whether to ask the pilot to submit an incident report.

All pilots, flight attendants, mechanics and dispatchers were issued a tag for their lanyard that listed the safety reporting programs available to them.

Pilots could send an email to report a concern which was quick and easy and could be done from their iPad. WBAT also now had an app for the phone where pilots could submit a report.

WBAT reporting (incident and ASAP reports) is the most likely reporting method.

If a pilot came to him about a concern with the localizer at an airport, he would call the director of operations and/or the chief pilot.

He always encouraged those who reported to him to also submit a WBAT incident or ASAP report. The differences between the programs were explained in training. WBAT allowed the reports to get in right away so people could see it immediately. If someone submitted an anonymous incident report in the suggestion box, that would be entered in WBAT.

Asked whether it was better to submit to WBAT[2] or ASAP, he thought ASAP was a more recognizable and promoted program and removed the fear of the pilot "throwing themselves under the bus" in the eyes of the FAA.

Every incident report filed got a response that the report was received and what would happen next. After the safety committee reviewed the report, the person would get a follow up email with the notes pertaining to their report's review.

There was no communication to his knowledge that CommutAir solicited reports from pilots after the accident. One pilot reported a localizer anomaly to Boston Center before the accident. Boston Center took the report, but he did not know what happened to it afterwards.

Both ASAP and incident reports were reviewed quickly. If it was an incident report, all managers got the narrative. For ASAP reports, ERC members got the reports. The ERC consisted of the ASAP manager, a company representative for the employee group, a union member, and a FAA member. The ERC members would all get notified immediately.

He honestly could not say whether receiving a report the night before the accident about the localizer would have stopped the accident. He also thought most pilots, especially at the end of their duty day, did not immediately report an issue and would wait until the next day.

Pilots could call the hotline and leave basic information about an issue; doing so would give them an extension on filing the incident or ASAP report.

They were looking at ways to improve reporting, and to improve awareness of things that needed to be reported. This was discussed during basic indoc but pilots in training were "drinking through a fire hose" and were focused on passing the checkride. They had not fully evaluated this yet but discussed saving topics like SMS and safety reporting until after IOE.

They needed to know that the data being pushed out was valid data.

There were no WBAT reports submitted about pilot deficiencies; he should not say never but he did not recall any since 2012.

He requested the tapes be pulled for when the CommutAir pilot who landed the night before reported the localizer devation to Boston Center. He looked at Live ATC or Flight Aware to get the tapes but was unable; their POI was able to get the actual tapes of the report. After that pilot landed and cancelled his IFR flight plan, the pilot reported a dot and a half off all the way to touchdown.

The safety hotline was monitored daily; it was a voicemail to the safety director and he checked it each morning when he got in. The voice message told the caller to contact dispatch if it was an emergency. The SOC duty manger and dispatchers were a great source of information. There were

[2] In an email dated March 22, 2022, the CommutAir party coordinator (interviewee) clarified that WBAT was the online reporting tool that collected reports.

Level 1, 2 and 3 alerts. He thought 95% of the time that something was reported to dispatch it was an operational issue not a safety issue, but he still got an email for every report made.

A person could not submit an anonymous report through WBAT, only through the hotline or safety concerns suggestion box which was online. When a report was submitted[3], it would go to him, the COO and the chairman of the board. Reports would be given to the safety department and entered into WBAT as incident reports.

He was only aware of an issue with the navigational aid into Buffalo which had been NOTAM'd for a while.

He thought pilots were very aware about inaccurate field condition reporting at PQI because it had been included in the daily read on the dispatch paperwork. He also thought it was included that the frequency to turn on the approach lights was different than CTAF. No localizer issues were ever reported (before the accident) or placed onto the dispatch release for PQI.

This past winter was their first winter flying into PQI so he was not sure if there had been an issue with the localizer before.

He had nothing to add to the interview.

The interview ended at 1625.

[3] In an email dated March 22, 2022, the CommutAir party coordinator (interviewee) clarified this was referring to reports submitted through the safety concerns and suggestion box.

Interview: Derek Richard Sharp, Safety Program Manager, CommutAir
Date/Time: May 21, 2019, 0902 EDT
Location: CommutAir Headquarters, North Olmsted, Ohio
Attendees: Marvin Frantz, Katherine Wilson – NTSB; Nicholas Biondo – ALPA; Zack Barrett – CommutAir

Representative: John Darke, Director of Safety, CommutAir

During the interview, Mr. Sharp stated the following:

He had held his current position since he began at CommutAir 22 months ago. Prior to that, he had spent 11 years in the Marine Corps, as a CH-53 pilot and safety officer of the squadron. He held a commercial pilot certificate with airplane single and multi-engine land, rotorcraft, and instrument ratings. He had about 1950 total flight hours. His civilian flying consisted of obtaining his MEL in Honolulu, Hawaii.

He oversaw or chaired the meetings of a variety of groups, including the Safety Committee (which met the first business day of the week) where they reviewed incident reports from flight ops, inflight and dispatch; the Safety Review Board (monthly) for 119 and director level managers in flight operations and maintenance to discuss the overall safety of the organization, the ASAP program (for flight ops), the Emergency Response Program, and the Fatigue Risk Management Program. He analyzed various data to advise the Director of Safety about trending information. He reported to the Director of Safety.

The ASAP program was a voluntary reporting program to enhance safety "first and foremost" at CommutAir. Pilots, flight attendants, and maintenance personnel were covered in the program from certificate action when reporting safety information. The Event Review Committee (ERC) met to review and analyze any reports submitted in the program and review areas where safety can be enhanced at the company. Four times a year, he sent a quarterly ASAP report to the FAA and would brief the ERC on data such as the number of reports submitted and number of sole source reports. Last year there were 730 pilot reports submitted. Seven hundred and one were sole-source, meaning neither the FAA nor the company would have known about the issue unless it was reported by the individual. Last year, two reports were not accepted. The general themes of reports included momentary FAR deviations, speed-limit violations below 10,000 ft, and mis-understood communications like readback errors and using the wrong taxiway.

There were a handful of times a quarter where they got ASAP reports that should have been filed as an incident report; those were the types of things reviewed weekly at meetings. Regarding ASAP reports versus incident reports, ASAP was viewed by the FAA so if someone wanted the FAA to see it, they should file an ASAP. The company encouraged reporting of any means. They would sometimes call a pilot who submitted an incident report and ask if it could be converted to an ASAP report because it was a regulatory event. A pilot could not choose to submit both reports when filing one or the other. He would get an email notification that a report had been submitted. He got about 25 to 50 safety-only ASAP reports each year that did not involve regulatory compliance but were for safety awareness. Before the accident, there were no reports about PQI.

After the accident there were 5 reports (1 incident report and 4 ASAP reports) made spanning the period of 1 to 3 March indicating that the ILS was not aligned with the runway at decision height. He thought all five reports were made by pilots in visual conditions, where the airfield was seen well-above minimums. He was not sure why the reports came in after the accident. He was on travel at the time of the accident. He had not researched previous winter reports for this issue at PQI.

He thought the reporting culture at CommutAir was good. The company worked hard to create a positive, open environment with front line employees. He spread the word to the pilot group; he went to bases monthly and talked to crews. He thought they could improve but crews knew they could reach out to him if there were issues.

A report of this issue, if made before the accident, would be sent to the Director of Safety, who would coordinate with other officers to immediately develop a course of action. This was Monday morning quarterbacking, but he was confident the director of safety would have acted on it. Anyone who read a report can act on it in a timely manner if needed. He thought something as significant as was reported potentially would have been addressed. There was no process that a report needed to be reviewed in a given period of time; it was possible that a day or two would pass before a report was reviewed. He had not asked crews why they did not report the issue at PQI before the accident. ALPA had done some of that, but they did not tell him anything definite about what they learned. For one of the five reports submitted after the accident, the pilot reported contacting Boston Center about the issue on March 2. He had reached out to a contact in the ASAP program about it.

An email went out to the FAA, company and ALPA representatives, and the Director of Safety when a report was submitted; all representatives got an alert when an ASAP report was filed but the report was already de-identified at that point. Representatives were assigned to a particular meeting; it was only one ALPA and one CommutAir rep at the ERC meeting. Others would get the deidentified email.

The airline got about 1000 incident reports a year. There were a variety of ways for a pilot to submit safety information including the safety hotline, incident and ASAP reports. There was a mobile app for the reporting suite. Ideally, pilots would use WBAT for filing reports because they were able to see when a report was submitted even if they were not in the office and could take action. He was discovering how to enhance CommutAir effectiveness as a responder to reports, like how to make it easier to report and IT solutions to help them respond to submissions.

Emails were checked during nonworking hours to maintain situation awareness. He had from time to time brought other leadership into the loop during non-working hours based on a report. For example, there was a report from EWR that ramp lights were blinding, making taxi unsafe. There was an email sent to airport ops right away. They had resolution on it within 48 hours or less. This was one example where SMS worked; if you see something, say something.

He was not sure who at the FAA provided the company with the ATC recordings of the accident flight.

A 29-year veteran of CommutAir, reported to him. She helped administer and process reports. She also provides useful insights to line flying. The Environmental Health and Safety Manager, who did OSHA and dangerous goods as well, also reported to him. He could use more help in processing reports but they were able to maintain situation awareness. The Fatigue Risk Management Program was designed to allow a crewmember to call in fatigued and be taken off the schedule. A Fatigue Committee which included representatives from ALPA, the chief pilot's office, safety department and crew scheduling, reviewed monthly fatigue submissions. They discussed each report and looked at crewmember schedules for the previous 2 weeks, circadian shifts, maintenance or weather delays, and other concerns to see if anything could be addressed. He also attended those meetings or they would be rescheduled if he could not attend. He received less than three fatigue reports each month.

Prior to beginning service to PQI, flight operations did a Safety Risk Assessment (SRA). This was brought to the Safety Action Group (SAG), which met weekly, to determine what mitigations could be put in place. It was looked at and discussed by departmental leadership; there was also follow up after it was approved by the FAA and operations started. He remembered discussions about PQI at SAG meetings, about un-towered fields, in and out procedures. These discussions were before the accident. Since the accident, there had been no changes he knew of to the reporting requirements for crews regarding navigational aid discrepancies. After the accident, the SRA was reopened, crews were restricted to RNAV runway 1 approaches, and there had been a conversation with the field manager about FICON reporting. If a crew did not know the runway conditions, they could not proceed to landing. Also a take-off alternate was in effect for some period at PQI. CommutAir had two flights into PQI daily.

Pilots got messages through WBAT when they submitted a report. They got one email when they submitted a report, and another email when it was closed out and any discussion notes from the meeting. An incident report could be closed out in a week; an ASAP report could take up to a few weeks before anything was sent to the reporter.

He co-taught safety training to pilots. The training included company goals and objectives in safety, current rates, hazard identification, the just-culture policy, and ways to report. The general message was that the front-line employees were the eyes and ears of the company and without their reports the company acted under assumptions so the more reports they received the better. They used examples of reports they had received to let trainees know the company would not have known about it without their report. There was an uptick in reports in March; April 2019 was the highest in history with 109 reports. This may have been because of the accident, the monthly telecon with the ALPA Safety Committee which started in January 2019, trending items in ASAP, fatigue reporting. They would go out on a monthly basis and talk to crews and maintenance technicians; they wanted to be as visible and approachable as possible. It all trickled down from ALPA members.

There was a lag time in ASAP report distribution to others such as flight operations due to the de-identifying process, (a manual process in which he or a staff member would deidentify the reports), versus incident reports, which went out right away. They were not de-identified. Only the ERC received ASAP reports immediately.

ASAP data was available on the ASAP data scoreboard which lists 6 months of closed out reports. Employees can only view ASAP reports from their own employee group (for example the pilots could not see maintenance ASAP data) and were told about this during initial and recurrent training, letting them know it was available to help enhance situation awareness.

The SAG was a committee that met weekly as a vehicle for the operational department to review SRAs; there were things in SMS that required an SRA. They analyzed risks and collaborate on interfaces between departments. It was chaired by the Director of Operations. The safety department also reviewed other pertinent information, such as when they received an incident for a rejected takeoff for a yaw damper, they recommended it be reviewed by SAG. As the safety department, they were a part of that process by attending or recommending things be discussed in that meeting. The Safety department was only one department which provided data and topics for SAG meetings.

He did not have the responsibility to visit airports during an SRA; he did not review charts. His involvement was relatively limited; he was there for the SRA review. There was a flight operations and airport operations component that did that assessment to visit airports and determine concerns. His role was to participate in the SAG and ask questions if he had them.

Crew pairings and experience was a conversation before they resumed flights to PQI. They first required a line check airman to fly into that airport. Traditionally, that was not one of his responsibilities.

Some ways for airline personnel to report safety concerns included the safety hotline, emails to the safety department, on-line and physical safety concern/suggestion boxes, WBAT on-line, and the WBAT mobile app, and his email and telephone; this was all shared during training. A lanyard tag issued to pilots during indoc had most of these methods listed, as well as in the GOM. The most commonly used was the WBAT system, the least commonly used would be his personal email and telephone information. The hotline was a recorded line and was originally set up for someone to report an issue who could not submit the report via WBAT in the required timeframe.

A direct call to himself or the Director of Safety was the most immediate method for reporting critical information.

The PQI event was challenging for the company. There were lots of lessons learned; they were very fortunate and would learn a lot from this.

The interview ended at 1010.

Interview: Matthew Robert Krajcik, Manager of Regulatory Compliance and FOQA Manager, CommutAir
Date/Time: May 21, 2019, 1030 EDT
Location: CommutAir Headquarters, North Olmsted, OH
Attendees: Marvin Frantz, Katherine Wilson – NTSB, Zachary Barrett – CommutAir, Nicholas Biondo – ALPA, Eric West – FAA

Representative: John Darke, Managing Director of Safety, CommutAir

During the interview, Mr. Krajcik stated the following:

He had been the manager of regulatory compliance for about 2 years and the FOQA manager for 10 days. He was hired by CommutAir in June 2017 and had held no other positions with the company.

As the manager of regulatory compliance he was responsible for the communication and coordination with the POI. He was also responsible for the safety assurance system and when findings came to his group he would distribute them to the appropriate party, such as flight operations or maintenance, monitor the progress and follow up with the FAA on a regular basis. He also did the filing and tracking of voluntary reporting program[4] for when a potential violation was uncovered. Last, he worked with CAST (commercial aviation safety team) on projects on behalf of the airline.

As the FOQA manager, he was currently trying to get it all set up and familiarizing himself with the key players; he was in his infancy with the program. Once he was up to speed, his day to day duties would include data analysis, looking at the events that come through each day in accordance with the FOQA manual and report the information as needed. He would eventually do training briefings at the new hire and recurrent training classes.

Prior to being hired by CommutAir, he worked for the *National Geospatial-Intelligence Agency* (NGA) in St Louis, and before that at Express Jet as a FO. He held an ATP certificate and EMB145 type rating. His total time was about 2400 hours.

Cockpit ride alongs were not currently required for his position but it was something being considered "moving forward". He clarified that this change was not related to the accident but rather something they thought would be beneficial.

He was not sure why the previous FOQA manager left the position but he thought it was somewhat unexpected.

Since the accident, he had looked at past FOQA data for flights into PQI at a cursory level; there was nothing in the data considerable at this time.

[4] In an email dated March 22, 2022, the CommutAir party coordinator clarified that the voluntary reporting program was called the Voluntary Disclosure Reporting Program (VDRP).

The data reviewed for FOQA was potentially 2 weeks old so they were always looking at things from the past. The data was downloaded during the 100 hours service check which happened about every 14 days. If they were aware of the localizer issue at PQI, the data they were looking at on March 4 would be data from February. New data usually came in every day from an aircraft or two that was in maintenance.

The system they used for FOQA would flag information as a caution, warning or alert. The list of parameters that would be flagged was huge; it was hundreds of parameters. He thought a localizer deviation would be caught under unstabilized approaches.

If he saw something in the data that was egregious or intentional, he would go to the gatekeepers who would work with the union to identify the crew and provide counseling if needed. The FOQA data would be used to see if there was an airport more at risk of unstabilized approaches and to improve safety and training.

Because he was only looking at a few days of data from PQI after the accident, it was hard to know what was normal.

When he received the data, it would show that aircraft's activity; he could see data from that aircraft and every airport it went to. He would have to filter by airport to compare across multiple aircraft. He could also do an event search, for example of all landings at CLE on runway 6R. He could also look at unstabilized approaches on a given runway. He was not sure if it was specified in the FOQA manual but he had looked at unstabilized approaches several times because it was an important topic.

He held weekly meetings with the director of operations to look at a weeks' worth of information. His goal was to do a monthly letter to the pilot group discussing the biggest trends. He would also create a list of action items for the training department. He thought the newsletter was previously done quarterly but he wanted it to go out monthly; this change was not related to the accident. He would also send quarterly reports to the FAA showing trends in the data.

When he was being trained to be the FOQA manager, he was told about ASIAS (Aviation Safety Information Analysis & Sharing) and anticipated being fully involved.

At the weekly meetings he held, they talked about typical events; he also met with the director of operations to talk about things he was seeing in the data. The weekly meetings were informal to brief what he had seen.

If he saw a safety concern, he would elevate it to the director of safety and the director of operations.

He did not think he ever had to submit a safety concern to the company. He had dealt primarily with regulatory compliance. In his regulatory role, he might have noticed a signature missing. He would follow the SMS process to report safety concerns and if he saw something the SMS process was to fill out a corrective action report and send it to the appropriate party.

The short term plan was to put out a job announcement for someone to help look at the day to day data. It was manageable for him now but would not be soon as the company grew.

He did not believe there was a designated amount of time that the FOQA data had to be processed by after it was downloaded. He would look at the data immediately, the same day, after it was downloaded from an airplane. It may take a few hours to review and validate the data. It depended on how many events there were, but it usually took him more than an hour to look at an aircraft's data. He would look at the data and validate it by looking at the circumstances of the events. If he saw something that required the crew being contacted, that request did not take more than "30 minutes or so" to make.

If an event was flagged in the FOQA data, it would show a caution for an unstable approach or when the flap extension speed was exceeded, for example. He would go to that approach and pull up the parameter data and then could filter down and determine in a few minutes what was going on.

Currently, he thought his duties as FOQA manager would take up more of his time than in regulatory compliance. When an analyst was hired, the "day to day" grind would be relieved and it would probably be a 50/50 split.

His role in this accident investigation was to help complete and submit the NTSB 6130 [sic] form along with the managing director of safety; he only did administrative work related to the accident.

At NGA, he worked as an aero intel analyst in the aeronautical charting office doing tasks such as flip publications and terrain assessments in eastern Europe.

FOQA looked at unstabilized approach parameters and he could best describe it as a 1000 foot snapshot and a 500 foot snapshot of 10 parameters measuring energy management, flaps, gear, power, etc.; it was dependent on the phase of the approach and whether all 10 parameters were met.

The accident flight would not have been flagged for a localizer deviation because the airplane would have thought the flight was on the localizer.

If the flight had an excessive angle of bank to correct for being off centerline, that could trigger an event. If the flight had corrected to runway centerline, he believed that was a parameter that should have flagged. Whether it flagged would depend on the size of the deviation. There were no triggers from the previous 5 flights before the accident that experienced the incorrect localizer. After he received a safety report, he could do a lookback but that was not the intent of FOQA. He needed to be careful not to violate the MOU when doing a lookback.

He had not encountered a situation where he received a report from the field and matched it to FOQA data to identify trends. It was hard to say looking back as to what he would have done before the accident. He thought it was a good idea to do a lookback from a safety report. (His representative added that the MOU with ALPA prohibited them from linking ASAP and FOQA data). Mr. Krajcik did not routinely review incident and ASAP reports although he could. (His

representative added that if they noticed a trend in ASAP reports, they could go back and look at FOQA data to see if they had any issues.)

He could push up data of concern to the gatekeepers who had access to FOQA data or identifiable characteristics of the flight. If it was trend data, he would create a list of action items moving forward that would be discussed at the monthly meeting. If he saw something that really shocked him he could elevate it or go through the pilot/gatekeeper route.

The company had "real time" ways to get information to crews; training was a long term fix.

He thought FOQA flagged a go around, passenger comfort levels exceeded, a hard landing and an unstabilized approach; he was not sure if an unstabilized approach would be flagged for the accident flight because airspeed, localizer and glideslope were okay.

He clarified that the data for each aircraft was continuously being monitored but there were 1000 foot and 500 foot gates when an unstabilized approach event would go from a caution to a warning.

He thought the lateral deviation parameters should get narrower as the flight got closer to the runway but he had not seen that yet.

"Real time" ways to get information to crews included the dispatch release daily reads, crew memos, monthly flight operations newsletters, and calibration letters from flight standards to check airmen.

Asked if SMS and FOQA were siloed right now, he said maybe. It sounded to him like they needed SMS to work better with FOQA within the bounds of the MOU.

The FOQA program manager would make regular visits to the company training center; that was another communication avenue with crews.

The interview ended at 1125.

Interview: Jacob Lofting, Director of Operations, CommutAir
Date/Time: May 21, 2019, 1230 EDT
Location: CommutAir Headquarters, North Olmsted, Ohio
Attendees: Marvin Frantz, Katherine Wilson – NTSB; Nicholas Biondo – ALPA; Zack Barrett – CommutAir

Representative: John Darke, Director of Safety, CommutAir

During the interview, Captain Lofting stated the following:

He had been the Director of Operations (DO) since July 2018. From his date of hire in April 2007 till 2012, he had been a line pilot, ground and simulator instructor, and line check airman for CommutAir in the Dash 8 airplane. Between 2012 and July 2018, he had held various management positions at CommutAir, including Dash 8 Program Manager, Chief Pilot, and Assistant Director of Operations. He started flying in 2000. From 2002 till 2005, he attended the University of Central Missouri, where he earned various pilot certificates and then was a flight instructor until 2007. He held an ATP certificate with Dash 8 and E-145 type ratings. He had approximately 5200 total flight hours.

He had first learned of the accident from the CommutAir Director of Safety who had learned of the accident from the United Airlines Express (UAX) Director of Safety.

The WBAT system was the standard system for submitting safety-related reports at CommutAir. These included incident reports and ASAP reports; he believed there was also a check box to submit an ASRS report. He did not immediately read all reports that were submitted when he was notified of them. There was a Flight Data Analyst who reviewed reports right away and was tasked with dealing with any time-critical information found in the reports. Per their SMS process, this would include notifying the appropriate managers and directors if action was needed.

The previous DO still worked at CommutAir in another position.

He believed the captain had a failure in training, possibly for a V1 cut, and was appropriately retrained; he thought if the failure happened before July 2018, he would have been in the assistant DO position. Since the accident, the Director of Training had reviewed the accident crew's training records. The former Chief Pilot had briefed him about the 6-month hold back for upgrade that the accident captain had been subject to previously due to a disciplinary issue. Other than the training failure that the captain had experienced in her upgrade attempt, she had not risen to his attention during his time as the DO; he thought the director of training would have reviewed her PRIA records.

He had met the accident captain but had never flown with her and as DO, had no interaction with her. He did not know the accident first officer until the accident; he knew the FO had been at CommutAir for less than a year.

He flew for the airline, maybe 60 hours every 6 months.

He had never flown to PQI with CommutAir. The company had only been flying there since July 2018. Some issues the airline had experienced flying into PQI included obtaining accurate FICON reports and Runway Condition Codes, complying with the PPR requirement, and getting in touch with the airport. To address the FICON issues, they made sure every flight to PQI had thrust reversers working. Crews were also following CommutAir procedures and not landing at PQI unless they get ahold of the airport and get a PPR.

His duties and responsibilities as DO included maintaining operational control of the airline, chairing the Safety Action Group, and assuring regulatory and safety compliance. He reported to the Vice President of Flight Operations.

It was not uncommon to hold someone back from upgrade, usually for disciplinary issues like not being truthful or attendance issues. This type of thing would normally be discussed by him and the chief pilot. ALPA would also be involved if there was a predisciplinary hearing. The relationship between the company and ALPA was pretty good. Growth of the company made it challenging and harder to maintain the relationship. There was no hostility and they were "pretty open" with each other. Senior management, such as himself, the director of flight standards, and vice president of operations, were Executive-Inactive status with ALPA but they still paid dues.

He could see the report narrative instantly or with one-click when he received notification that a safety report had been filed. Some reports had narratives, and some had a link for more information. If it was a flight ops report, he would get a narrative but inflight would have to click on it. The best way to quickly get a safety report up the chain was to call a flight manager; one was available 24/7. He thought there were 5 flight managers, including him, and each would take a shift. He had operational control but each of the flight managers would take calls and help lighten the load. A pilot could also call dispatch and talk to the on-call pilot (flight manager).

He did not have regular dealings or a direct relationship with United Airlines Express but had spoken to their director of operations[5] before.

He did not do hiring interviews anymore as the chief pilot was ultimately responsible. There were others also involved in the interview process who were pilots. The chief pilot would review PRIA records and the new hire checklist. Pilot pay at CommutAir was about on par with other carriers. Hiring was meeting the company's needs now.

He believed pilots were comfortable with safety reporting. He thought they had a good culture at CommutAir "for the most part." If a pilot reported a safety concern or a concern related to a violation, they had a good history working with the FAA to let them know things would be handled justly through the ERC. He thought pilots were comfortable based on CommutAir's history of handling reports.

[5] In an email dated March 22, 2022, from the CommutAir party coordinator, the interviewee clarified that he had spoken with the Director, Safety and Compliance for United Express, not the director of operations.

He did not know why issues with the PQI localizer before the accident were not reported until after the accident. Maybe the pilots did not have enough time to report before the accident, or maybe they did not see it as a safety concern like they should have.

The company did not send out any solicitation of reports, but he sent out a communication within a few days of the accident to let people know what was going on; maybe that prompted the reports which were made after the accident. It was not until the memo for return to service that the company told pilots to report safety concerns.[6]

There was a new TR in the GOM which stated that any Navigation aid discrepancy or anomaly was a required report. This was inferred but not explicitly stated previously.

Any changes in procedures or the manual system went through a Safety Risk Assessment (SRA) process. The SRA was reviewed by the safety action group every Tuesday to determine the risks and how to reduce the risks.

As a flight manager, he would get a call or email from a pilot or dispatcher if immediate action was required due to a new safety report. An example at PQI was when he got a call from the SOC duty manager in reference to a dispatcher's concern that a pilot reported via ACARS not being able to get a FICON report. He told them to turn the aircraft around.

Methods for getting safety information to crews included the Pilot Daily Read on the dispatch release and memos to the crews using Comply365 on the iPads. Revisions made to manuals were "compliance documented". Memos to crews were not compliance documents. To access the memos, a code had to be typed in to the system; the expectation was that people would read the memos.

He reviewed the SRA for PQI after the accident. The changes made included that the runway lights should always be on highest intensity for takeoffs and landings, the runway, up to the 1500-foot markings, must be identified before descending below the MDA, and the centerline must be visible before departure.

Regarding pilot reluctance to submit safety reports, he thought it might be the perception that it could result in punitive action but the Safety Department told pilots in ground school that this was a safety system, pilots were not getting reported for submitting a safety concern, and very few reports did not get accepted.

The part 119 Chief Pilot signed off on PRIA records checks. If issues came up, they would be brought to his attention. Being fired from a previous position, if disclosed by an applicant, would not be an anomaly.

Drug and alcohol testing was required after an accident. He thought it was accomplished in this case.

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[6] In an email dated March 22, 2022, from the CommutAir party coordinator, the interviewee added "We've always required them to report safety concerns per the GOM, but emphasized it further with communication after the incident."

He had read the crew's statements, but had no information concerning the NTSB interviews of the accident crew. The crew filed ASAP reports. They went through the ERC and were not accepted. This was because of egregious activity on the part of the crew and SOPs not being followed. He was not on the ERC but that was his understanding of why they were not accepted. The number of non-accepted reports was very low.

The Flight Manager was also known as the on-call pilot. This was a rotating position, and could be the Director of Safety[7], the Director of Training, the DO, the Chief Pilot, assistant Chief Pilot, or the lead Technical Pilot. The on-call pilot role helped pilots know who the flight managers were and that they were not just "some manager" but pilots as well.

Regarding the current hiring situation for pilots, the economy was doing well and lots of captains were moving on to other legacies and major airlines. The company was short on the captain side, and there was a surplus on the FO side. While in the training pipeline, new FOs who met the Part 121 requirements for captain could transition to the PIC pipeline if classes were available.

This accident was his first time working an emergency. The initial reporting of the accident to CommutAir came through United rather than the CommutAir system. They lost a little time, about 10 minutes, because of this, but once made aware, CommutAir acted quickly and decisively. Overall, he thought they did a good job. One thing he thought could use improvement was to ensure that the station knew who to notify in the event of an accident.

He had nothing else to add to the interview.

The interview ended at 1430.

[7] In an email dated March 22, 2022, the CommutAir party coordinator clarified the director of safety was not a flight manager.