

Group Chairman's Factual Report - Attachment 1
Interview Summaries

AIR TRAFFIC CONTROL

DCA21FA174

Interviewee: Christine Pascua
Representative: Matt Picciotti

Date / Time: July 5, 2021 / 1334 HST
Location: Hawaii Control Facility, Honolulu HI
Present: John Wennes, Amy Huschka
Investigator: Charles Olvis

During the interview Ms. Pascua stated the following:

Ms. Christine Pascua began working for the FAA in September 2006 as a Collegiate Training Initiative (CTI)¹ hire from Mt. San Antonio College and reported to the FAA Training Facility, Oklahoma City, OK. She graduated from the training facility in November 2006 and reported to Atlanta Terminal Radar Approach Control (A80 TRACON²). In July 2014 she departed A80 and reported to Honolulu Control Facility (HCF) in Honolulu, HI working in the Island Specialty. In February 2015, she accepted a position as a Front-Line Manager where she has remained.

Ms. Pascua's medical certificate was current with an eye correction exemption. She was wearing contacts at the time of the accident. She did not hold any other aeronautical licenses and was certified in the Island Specialty and proficient on the Maui Approach sector.

Ms. Pascua's regular days off (RDO) were Saturday and Sunday. On Mondays she worked a 1400 to 2200 shift, on Tuesdays she worked a 1000 to 1800 shift, on Wednesdays she worked a 0600 to 1400 shift, on Thursdays she worked a 0600 to 1400 shift, and would come back at 2200 on Thursday until Friday morning at 0600.

On Friday July 2, 2021, Ms. Pascua was working a 2200 (July 1, 2021) to 0600 shift. She reported that she felt well rested and had slept for about two and a half hours after coming off duty at about 1400 earlier that day. She reported nothing unusual with her family life or any financial situations that would have added stress to her routine. She signed in at 2200 that night and felt that she was alert and good for work. Ms. Pascua said that after arriving at work she would normally review notices to air mission (NOTAMS³), review weather, and assume the operations manager in charge (OMIC)

¹ A non-funded partnership between selected colleges and universities and the Federal Aviation Administration (FAA). Graduates of AT-CTI programs have broad-based aviation degrees that include specific air traffic curricula.

² FAA facilities that house air traffic controllers who guide aircraft approaching and departing airports. TRACON controllers generally handle within a 30- to 50-mile radius of an airport and up to 10 000 feet, as well as aircraft flying over that airspace. They are responsible for the safe separation of aircraft flying in the areas surrounding airports.

³ A notice containing information essential to personnel concerned with flight operations but not known far enough in advance to be publicized by other means. It states the abnormal status of a component of the National Airspace System (NAS) - not the normal status.

position for the evening. She reported there were no staffing issues on the night of the accident.

Ms. Pascua became aware of the emergency involving Rhoades 810 (RDS810) when Ms. Shiraishi, who was working the combined tower and TRACON (TRACAB) positions in the air traffic control tower (ATCT), called and advised that RDS810 had lost an engine and was returning to Honolulu airport. Ms. Pascua reported that Ms. Shiraishi had contacted the fire department through established reporting procedures. Ms. Shiraishi contacted Ms. Pascua a second time and asked that the R3 Honolulu center sector be made aware that RDS810 would be returning to Honolulu International Airport (HNL) and not going to Maui.

Ms. Pascua reported that she walked over to the TRACON radar display to observe what was going on when Ms. Shiraishi called back and advised that it did not look like RDS810 would make it. Ms. Pascua asked Ms. Shiraishi where the airplane was, and she reported the airplane was 12 miles southwest of the airport.

Ms. Pascua stated that she contacted the United States Coast Guard (USCG) on the Remote Digital Voice Switch (RDVS⁴). She stated that she passed to the USCG the type of airplane and the last position report that she was aware of and reported that the airplane had lost an engine and may go in the water. Ms. Pascua stated that the USCG was going to start assembling assets for the emergency.

Ms. Pascua said that Ms. Shiraishi called back and said the airplane was lost on radar. Ms. Pascua went to the center sector and asked for the position of RDS810 on radar. The center sector controller reported the last target was about 3 miles southwest of Kalaeloa Airport (JRF). Ms. Pascua called the USCG back and advised them the airplane was in the water and provided an updated position. The USCG advised they were responding.

Ms. Pascua reported that she called Operations Manager Tim Long and left a voice mail regarding the accident and then contacted Operations Manager Mike Farmer and informed him of what had occurred. She informed Mr. Farmer that RDS810 was in the water and that the USCG was responding. She asked Mr. Farmer if he would contact the air traffic manager. She said that she requested a controller to come off break and relieve Ms. Shiraishi. She said that she gathered the required paperwork and cordless telephone for handling the emergency and proceeded to the ATCT to assist the controllers.

When Ms. Pascua arrived in the tower, Ms. Shiraishi had been relieved from position. She asked Ms. Shiraishi if she was "okay", and she reported yes. Ms. Shiraishi ran through the sequence once more with Ms. Pascua and reported that RDS810 had

⁴ Primary communications links between air traffic controllers and aircrews onboard aircraft.

departed and reported they lost an engine. The pilot had requested to run checklist and she provided an extended vector at pilot request. She reported that when the pilot said he could not join the localizer he stated that ATC may need to call the USCG. Ms. Pascua completed the required emergency paperwork and returned to the OMIC desk in the TRACON.

Ms. Pascua did consider the crash circuit being out of service (OTS) as an issue to safety. She said it had been OTS for a long time and had been on the 7230-4 facility log⁵ as a carryover item for a long time. She said that Ms. Shiraishi had reported the alternate reporting procedures and OTS crash circuit "a pain".

Interview concluded at 1415.

Interviewee: Jennifer Shiraishi

Representative: Jacob Kamakahi

Date / Time: July 5, 2021 / 1527 HST

Location: Hawaii Control Facility, Honolulu HI

Present: John Wennes, Amy Huschka

Investigator: Charles Olvis

During the interview Ms. Shiraishi stated the following:

Ms. Jennifer Shiraishi began working for the FAA in January 1992 as a direct hire from the FAA Training Facility, Oklahoma City OK. She graduated from the training facility in May 1992 and reported to Hilo, HI (ITO) air traffic control tower (ATCT). In January 1996 she departed ITO and reported to Santa Barbara, CA (SBA) ATCT. In August 2000 Ms. Shiraishi departed SBA and reported to HCF. She was qualified on all operating positions in the tower and terminal radar approach control (TRACON) and was designated a Controller in Charge (CIC).

Ms. Shiraishi's medical certificate was current with an eye correction exemption. She was wearing contacts at the time of the accident.

Ms. Shiraishi's regular days off (RDO) were Saturday and Sunday. On Mondays she worked a 1415 to 2215 shift, on Tuesdays she worked a 1415 to 2215 shift, on Wednesdays she worked a 0900 to 1700 shift, on Thursdays she worked a 0545 to 1345 shift, and would come back at 2200 on Thursday until Friday morning at 0600.

On Friday July 2, 2021, Ms. Shiraishi was working a 2200 (July 1, 2021) to 0600 shift. Ms. Shiraishi reported that she felt well rested and had rested for about 45

⁵ A written or electronic log that contains the status of various ATC equipment or events and incidents that occur during a watch.

minutes after coming off duty at about 1330 earlier that day and reported that she had about a 50-minute commute into work. She signed in at 2130 that night on credit hours. Ms. Shiraishi was working the mid shift in a TRACAB configuration in the Tower. They were landing and departing on Runways 4 R/L and 8 R/L.

Ms. Shiraishi was working all Tower and TRACON positions combined in the tower cab with multiple frequencies. She took the position at 1100 UTC and said it was "super slow". When RDS810, a Boeing 737-200, first taxied it was not that busy. She taxied him via the normal route of "Charlie, Romeo, Tango, Romeo, Alpha" and then cleared RDS810 for takeoff. She looked up to verify that the standard 155° right turn was being complied with and did not notice anything unusual with the airplane.

Ms. Shiraishi did not remember who she was talking to but heard something garbled from what she assumed was RDS810 but could not be sure. She radar identified RDS810 and assigned a heading to join V2 airway. Ms. Shiraishi cannot recall if she issued an altitude at this time, but she asked the pilot to say altitude and received no response. She talked to another aircraft then went back to RDS810 reissuing instructions to join V2 airway but with a more aggressive heading. At that time, she observed that RDS810 was on a 220° heading. She turned the airplane to a 180° heading because she had company traffic, RDS809, inbound from the south cleared for a visual approach. RDS810 said something about flying a 220° heading. When told again to fly heading 180°, RDS810 responded "unable we have one engine out".

Ms. Shiraishi immediately went to a company airplane, RDS809, and cancelled their approach clearance and turned them to a 240° heading. RDS810 took the instruction and she had to correct the pilots to make sure RDS809 received the proper instructions. Ms. Shiraishi immediately went back to RDS810 and cleared the pilot for the visual approach and said she assumed that if they did not have the field in sight, they would advise her. The pilot advised that they needed to continue the 220° heading to run a checklist. She issued the 220° heading and observed the altitude at 2,000 or 2,100 feet, so she asked if they would like to stay at 2000 feet. The pilot confirmed they would like to stay at 2,000 feet and she believed she reissued "maintain 2,000 feet".

Ms. Shiraishi then called the State of Hawaii ramp via the RDVS to inform them of a possible emergency. Procedures in place, due to an out of service (OTS) crash circuit, required Ms. Shiraishi to also call the Hickam Air Force base (AFB) ramp to inform them of the inbound emergency. Because the aircraft involved was not military, and she knew that the State of Hawaii ramp would be in charge, she delayed the call to Hickam. Higher priority duties required Ms. Shiraishi to hang up on Hickam ramp on at least one occasion during the accident sequence.

The pilot of RDS810 then asked to turn the airplane toward the airport but stated they were not ready to land. Ms. Shiraishi assigned a 250° heading. She had asked

once for souls on board and fuel remaining and was told to stand by. RDS810 then said they were ready to return to the airport so she turned them to a 020° heading and asked if they could join the localizer for Runway 4R. The pilot advised they were unable to join and requested a vector. Ms. Shiraishi assigned a 040° heading and then later a 050° heading because they were still north of the localizer and did not have the field in sight. The pilot said the number two engine was running hot and the airplane speed was not looking good. The pilots then advised that there were two souls on board and 2 hours of fuel.

The pilot mentioned calling the Coast Guard. Ms. Shiraishi called down to the OMIC to ask Ms. Pascua to call the Coast Guard as RDS810 was probably going in the water. She observed the airplane via the radar display at an altitude of about 400 feet and the Low Altitude (LA) alert activated. She told the pilot "low altitude" and asked if they could climb. The pilot responded negative they could not climb. Ms. Shiraishi turned the aircraft to a 060° heading and was told by the pilot that they still did not have the airport in sight. She suggested Kalaeloa (JRF) airport at their 9 to 10 o'clock position and 3 miles. The pilot responded whatever was closest. Ms. Shiraishi assigned a 310° heading to JRF. She observed the aircraft start the turn and went to check the status of the runway lights at JRF. Ms. Shiraishi advised RDS810 that the lights may be pilot controlled on frequency 132.6 but never received a response. She tried to contact RDS810 a few more times with no response and the radar track went into a Coast⁶ RADAR track. Ms. Shiraishi called the State of Hawaii airport fire Chief 2 who was in charge of the ramp response and advised them that RDS810 was in the water.

Ms. Shiraishi reported that she could not recall working another Rhoades Express airplane with an emergency before but felt like she probably had.

Ms. Shiraishi said that she had not observed the accident airplane as it was maneuvering southwest of the airport or impact the water.

Interview concluded at 1645.

⁶ Status of an aircraft that is no longer giving a radar return. The air traffic control screen will display this status (usually with the acronym "CST") and will temporarily continue displaying the aircraft's movement at the last heading and speed, as if it was "coasting".