

**Factual Report – Attachment 1**

**Interview Summaries**

**AIR TRAFFIC CONTROL**

**CEN17FA168**

**Interviewee:** Joshua Ray Click  
**Date / Time:** May 16, 2017 / 1100  
**Location:** Air Traffic Control Facility, Amarillo Texas  
**Present:** Bill Flavors, Erika Raun-Linde,  
**Investigator:** Andy Olvis  
**Representative:** Shay Bowling

During the interview Mr. Click stated the following:

Mr. Joshua Ray Click began working for the FAA in July of 2015. He reported directly to Amarillo ATCT (AMA) and later attended the Radar Training Facility course (RTF) in Oklahoma City, Oklahoma. After completing the course, he returned to AMA ATCT. He was fully certified on all control tower operating positions and was designated as a controller in charge (CIC). He also held radar data and surveillance approach certifications in the TRACON. Mr. Click was in training for the west radar and finals operating positions.

Prior to the FAA, Mr. Click served in the United States Air Force from November of 2007 until September of 2014. He was initially a bioenvironmental engineer and later cross trained into air traffic control in 2012. He was stationed at McConnell Air Force Base (AFB) in McConnell, KS and held all tower certifications, but did not receive his watch supervisor designation. He held no other current aeronautical certifications and his ATC medical was current with no restrictions.

Mr. Clicks regular days off (RDOs) were Wednesday and Thursday, and it was common to work two hours of holdover overtime (OT) during his first two shifts of the week. This was due to poor staffing, and having too many trainees with too few trainers. Mr. Click was not designated as an OJTI.

On Friday, April 28, 2017, Mr. Click was working a shift of 1415-0015, including two hours of holdover OT. He remembered it was a typical day, which consisted of signing in, reading the read and initial binder, and being assigned to a control position about 30-45 minutes after arriving. Mr. Click normally started in the control tower, but could not recall what position he began with on the day of the accident. He remembered rotating through positions and receiving breaks as normal.

It was routine for Mr. Click to obtain local AMA weather conditions in the position relief briefing when assuming position. At about 2200, he assumed the local control position combined with ground control and clearance delivery. He remembered the weather being IFR with a visibility of 10 miles and low ceilings, and winds out of the north; he believed they were gusting to about 30 knots. He remembered a few AMA arrivals between 2200 and 2300.

The pilot of LN933DC contacted ground control for a clearance to Clovis, NM. Mr. Click issued the pilot a clearance "as filed" and instructed the pilot to taxi to runway 4 at taxiway "A" for an intersection departure. The intersection departure was a standard operation due to the location of the hangar where LN933DC was parked. Mr. Click called the TRACON with a taxi call to indicate the aircraft would be departing soon. He issued the pilot of LN933DC on course

instructions and cleared him for takeoff. He then called the TRACON with a “rolling call” and noticed the accident aircraft was on the wrong beacon code. He then instructed the pilot to change to the correct code, and after observing the correct code on the tower display workstation (TDW), he instructed the pilot to contact departure. Mr. Click visually observed the aircraft disappear into the clouds very quick after departure. A short time later, he observed a 30 to 40 foot high explosion fireball south of the airport terminal; he initially hoped it was a train since there was train activity in that area. Mr. Click contacted the west radar controller to ask if he was still communicating with the accident aircraft, and the west radar controller advised that he was not, so Mr. Click activated the crash phone.

Mr. Click was familiar with and able to state the requirements for soliciting PIREPs<sup>1</sup> per FAA Order JO 7110.65 *Air Traffic Control*. At the time of the accident, the reported weather required the solicitation of PIREPs. Mr. Click remembered three regional jets had arrived on runway 4, the last one about 20 minutes prior the accident. He had not requested a PIREP from the last arrival, but had provided the pilot with a previously received PIREP that reported bases at 4100 feet. That PIREP had been passed to the west radar controller, and he assumed that it had been input into the AISR<sup>2</sup>. The procedure for the facility was that the tower controller would pass PIREPs to the TRACON and the radar controller would enter them into the AISR system.

Mr. Click did not request a PIREP from LOF4782, the last arrival, and did not pass the previously received PIREP to the pilot of LN933DC because it was an arrival PIREP and LN933DC was a departure. He felt that bases and tops might have been useful information to the pilot of LN933DC.

After activating the crash phone, Mr. Click closed the tower and the west radar controller started the emergency procedures checklist downstairs, including the notifications and the 7230-4 *FAA Facility Log* entry. The ATM arrived after the accident and started the covered event review (CER)<sup>3</sup> process. The ATM asked Mr. Click about what happened and asked if he had solicited and passed PIREPs. The ATM said that things “looked good on our part”, but there were no further discussions about the accident. Mr. Click filed an Air Traffic Safety Action Program (ATSAP) report on the accident the following morning.

Mr. Click was certain that he had solicited a PIREP from one of the arrivals and passed it to the LOF4782 arrival, but was not sure where it was recorded; however, it was not on the tower PIREP log. The tower PIREP log was normally taken downstairs at about 2200 so that it could be included in the bundling of the days logs. This meant there was no PIREP log from 2200 until 0000 when the tower was closed.

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<sup>1</sup> PIREP is a pilot weather report that is solicited or disseminated by air traffic controllers.

<sup>2</sup> Aeronautical Information System Replacement is a web-enabled, automation means for the collection and distribution of Service B messages, weather information, flight plan data, Notice to Airmen (NOTAM) messages, Pilot Report (PIREP) message, and other operational information to all Federal Aviation Administration Air Traffic facilities.

<sup>3</sup> A CER is to supplement and document the existing required review of air traffic services rendered during an aircraft accident.

Mr. Click remembered receiving PIREP refresher training in March of 2017, but was not sure whether it was through computer based instruction or by another training format. He could not remember receiving training on the national emphasis items.

As a tower controller, Mr. Click would issue precipitation to the departures if he felt like it was a factor; but in this instance the precipitation was displayed on radar to the north and not the south which was the direction the aircraft would be turning to. Mr. Click said that the facility was solely dependent upon PIREPs for low level wind shear (LLWS). They had no equipment to assist in detecting LLWS.

Interview concluded at 1230.

**Interviewee:** Justin Britten

**Date / Time:** May 16, 2017 / 1500

**Location:** Air Traffic Control Facility, Amarillo Texas

**Present:** Bill Flavors, Erika Raun-Linde, Shay Bowling

**Investigator:** Andy Olvis

**Representative:** Shay Bowling

During the interview Mr. Britten stated the following:

Mr. Justin Britten began working for the FAA in January of 2010 reporting to the FAA training facility in Oklahoma City, Oklahoma. After completing the tower course, he reported to AMA ATCT/TRACON for duty. He was fully qualified on all operating positions in the TRACON and control tower, and was designated as a CIC. He became a Front Line Manager (FLM) in March of 2014, and resigned as FLM in March of 2016 but remained certified professional controller (CPC).

Mr. Britten's prior ATC experience was from August of 2008 to January of 2010 at North Texas Regional Airport/Perrin Field (GYI), in Sherman/Denison, Texas, a non-federal contract tower. He had also served as an air traffic controller in the United States Air Force from December of 2002 to August of 2008 at Altus AFB, in Altus, OK. He was a licensed private pilot, single engine land, and maintained currency flying about 50 hours per year. His medical was current with a restriction for corrective lenses which he was wearing at the time of the accident.

Mr. Britten's RDOs were on Wednesday and Thursday and he routinely worked an average of 8 to 16 hours of OT per pay period. He said the OT was usually as a "front side" holdover by coming in 2 hours early on Friday and Saturday. On the day of the accident, he was working a scheduled holdover shift of 1415 to 0015.

After arriving at work on April 28, 2017, Mr. Britten reviewed the read and initial boards, checked email, reviewed the CRU-ART<sup>4</sup> system and the position assignments for the day. He would assume the first position about 45 minutes after arriving at the facility, and would work

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<sup>4</sup> CRU-ART is the official time and attendance system for both signing in/out for a shift and on and off positions.

about 1 to 1.5 hours per position. Mr. Britten would check the day's weather when he was assigned the watch CIC, and when receiving position relief briefings with off going controllers. He classified the weather on the day of the accident as moving from visual flight rules (VFR) to marginal VFR, to instrument flight rules (IFR).

At 2230, the facility combined all the operating positions to one position in the tower and one in the TRACON; Mr. Britten was comfortable with that staffing level. On the night of the accident, he had assumed the TRACON west radar position. He remembered that he had received a "taxi call" from the tower indicating that LN933DC had received a clearance and was taxiing to runway 4 for departure. He had responded to the tower controller that the aircraft was cleared to proceed on course. The next call he received was from the tower indicating LN933DC was rolling.

A short time later, Mr. Britten observed LN933DC depart AMA on the wrong beacon code and in a right turn. A short time later he observed the aircraft transponder switch to the correct beacon code. He believed the pilot had checked on the west radar frequency "out of" 6,000 feet msl. He radar identified the aircraft and watched to see if the aircraft was on course to Clovis, NM. He reached up to begin bundling the flight progress strips when he noticed the radar target had switched to a "coast" track. He felt the target was over the main bang<sup>5</sup> and attempted several times to establish communications with the pilot in order to have the pilot reset the transponder; however, there was no response. The tower controller called down on the landline and stated that he had seen a fireball.

Mr. Britten believed he had solicited PIREPs earlier in the day. He had signed on the west radar position at about 2200 and remembered requesting the tops and bases from several aircraft. He could not explain why they were not listed on the facility PIREP log. He also could not remember if he had solicited a PIREP from the pilot of LOF4782.

PIREPs and weather dissemination were a national emphasis item. He was aware of the details and remembered he had received a NATCA briefing on PIREPs. He also said that he was sure he had received the PIREP refresher training but could not remember any of the details of that training. He could accurately describe the FAA Order JO 7110.65 *Air Traffic Control* requirements to solicit and disseminate PIREPs.

Because the only FLM was restricted to working in the tower only, Mr. Britten would routinely be scheduled as the watch CIC. He would assume the responsibilities of the TRACON CIC and watch CIC a short time after arriving at work.

While the ATM conducted the CER, he did not interview or discuss the accident with Mr. Britten. He had also not provided any feedback on the findings of the CER.

Interview concluded at 1630.

**Interviewee:** James Adams

**Date / Time:** May 17, 2017 / 0900

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<sup>5</sup> The "main bang" is that area directly above the radar antennae where the radar cannot produce radar targets.

**Location:** Air Traffic Control Facility, Amarillo Texas  
**Present:** Bill Flavors, Erika Raun-Linde  
**Investigator:** Andy Olvis  
**Representative:** Declined Representation

During the interview Mr. Adams stated the following:

Mr. James Adams began working for the FAA in February of 2003 and was hired under the retired military controller program. He reported directly to Albuquerque ATCT (ABQ) until October of 2005 when he transferred to San Antonio ATCT (SAT) as a CPC. He became an FLM at SAT in 2009, and then accepted a temporary supervisor detail at AMA ATCT/TRACON in November of 2010. He accepted the position of ATM at AMA ATCT/TRACON in April of 2011. Prior to the FAA, he served in the United States Air Force at various military installations as an air traffic controller from April of 1981 until May of 2001. After retiring from the military, he worked at Stinson Municipal Airport (SSF) as a contract ATC employee from May of 2001 until February of 2003.

Mr. Adams did not hold any certifications at AMA ATCT/TRACON or hold a current medical certificate nor was he required to. His RDOs were Saturday and Sunday.

At the time of the accident Mr. Adams was at home and received a phone call from a controller at the facility informing him that there had been an accident. He called the District Manager, Rob Lowe and the facility union representative (FACREP) Shay Bowling, before he advised the CIC that he was on his way in to the facility. After he arrived at the facility, he obtained the accident information from the controllers, made sure they were alright, and started gathering information for the services rendered telcon (SRT)<sup>6</sup>. He followed the SRT checklist and prepared to conduct the SRT. At about 0315 on April 29, 2017, an SRT was conducted with members of the central service area (CSA) and FAA HQ. He passed the information he had collected, and recalled there was a brief discussion of the events by those included in the SRT. It was decided that no toxicology testing would be conducted on the controllers involved in the accident, and the accident was color coded “green” by FAA Compliance Services, with no follow up required. He then released the controllers, locked up the facility, and returned home. The airspace had been returned to Albuquerque Center (ZAB) at 0000 as normal.

Mr. Adams returned to the facility the following Monday and began to work on the CER. He reached out to the district for assistance since he had never done an accident package before. He continued working the accident package and answered all the data requests. He gathered the data for the CER on May 1, 2017, but officially opened the CER on May 2, 2017. In March of 2017, he had attended the quality assurance and quality control QA/QC class at the FAA training facility in Oklahoma City, OK where he was trained on conducting a CER. He did not conduct any interviews for the CER and was not sure if he was permitted to. He completed the CER himself and did not consider bringing anyone else onto the team. He had done it that way because of the timing of the event. He felt he could have asked the FACREP or FLM to assist, but felt the timing

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<sup>6</sup> SRT is a telephone conference conducted with the ATO Safety Event Response Group, the Director of operations, Mission Support Staff, Office of Accident Investigation and Prevention, Operations Control Center, the involved Facility and others as needed to review and assess ATO services associated with a significant or noteworthy event.

was not appropriate. There were no further discussions with the controllers about the accident after the night of the accident.

Mr. Adams had not performed a system service review (SSR)<sup>7</sup> for this accident and had based his follow up requirements on the CER. He said that the CICs were familiar with filing an mandatory occurrence report (MOR)<sup>8</sup>. He was aware that the accident was documented in the facility log, but was unaware that no MOR was filed. He received email notifications on his phone of MORs as well. Every day he reviewed the daily logs, MORs, flight progress strips, and PIREP sheets, that were included in the daily bundles.

Mr. Adams was aware of the weather conditions at the time of the accident from the information gathered for the SRT. The weather at the time of the accident required the solicitation and dissemination of PIREPs. When listening to the tapes from around the time of the accident, he heard the tower controller passing base reports to the prior three arriving aircraft, though he did not hear him solicit a new PIREP. He noticed that the PIREP that was issued was similar to the reported weather and did not hear the tower controller pass any PIREPs to the departure aircraft. When asked if he felt the PIREP from the arrivals would have been helpful to a departing pilot, he said he was not sure, but possibly.

Mr. Adams was aware of the requirement to obtain PIREPs hourly, but was unsure if the PIREPs had been obtained hourly the night of the accident. He had glanced at the PIREP data sheets, but did not look at them in detail. He was aware that the written PIREPs on the data sheets did not represent the requirement to solicit a PIREP each hour and was unsure if the solicited PIREPs had been entered into AISR. Mr. Adams was not sure how to pull the information to see which ones were entered.

After learning that the PIREPs obtained later on the evening of the accident were not entered into AISR, he was concerned that PIREPs were not being properly obtained and disseminated, to include entry into AISR. There was no management control on the accuracy and validation of the PIREPs entered into AISR. The procedure was that the tower controller passed the PIREP information to the radar controller and either the CIC or radar data controller would enter the PIREP into AISR. When the AISR system was installed, there had been a collaborative decision made by NATCA and management to disseminate PIREPs that way.

While listening to the audio recordings, he heard the local controller passing 4,100 foot base reports to the last three arrivals before the accident aircraft departed. He did not observe the 4,100 foot base report on any of the PIREP logs, but did not question the controllers on this. He assumed that this had been a current PIREP that was being passed to the arrival aircraft, but did not listen to any earlier recordings to determine when the PIREP had been obtained. He was also not aware of the facility procedure of taking the PIREP logs downstairs to be bundled at 2200 each night, effectively removing any written documentation of obtained PIREPs after 2200. As of May 17, 2017, no change had been made to the facility standard operating procedure, but he intended to make a change regarding this practice.

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<sup>7</sup> An SSR is used to review the air traffic services provided in any situation at any time under any circumstances.

<sup>8</sup> An MOR is used to document an occurrence involving air traffic services for which the collection of associated safety-related data and conditions is mandatory.

The facility was under staffed and with only 10 CPCs on staff and projected to be down to 9 by June of 2017. There were 11 developmental controllers, 9 of those were tower certified; and a single FLM who was tower certified but held no certifications in the radar. There had been 2 FLMs until September of 2016 when 1 left for another facility. It was projected that AMA would be back to 2 FLMs in January of 2018. The facility was authorized 3 FLMs and there was a current bid out for another FLM. The facility support specialist left in October of 2016, and AMA was on the list to get another one; however, the region was currently at the full time equivalent allowed for support specialists, so until a slot became open, they remained without a support specialist.

There were competing priorities when it came to getting the FLM certified in the TRACON. He was getting pressure to cut OTand to get the FLM certified. They had an FLM from another facility come out once a month to complete certifications and skill checks in the TRACON since the assigned FLM was only tower certified. This was a decision made by the district manager and sometimes it was difficult to get them in the facility when needed.

Mr. Adams said that no one provided individual performance management (IPM) in the radar operation. Because the FLM was not qualified in the radar operation, IPM in that operation “just didn’t get done”. Mr. Adams felt a performance record of conference (PRC) had a negative connotation, and he would rather solve the issue with an on the spot correction rather than use a PRC. He also felt that he could not accomplish the feedback directly as the controllers do not fall directly under him in the chain of command. He confirmed that there had only been four PRCs done in the last two years; all four being completed in the last two months.

Interview concluded at 1100.