

Factual Report – Attachment 1

Interview Summaries

AIR TRAFFIC CONTROL

OPS17IA010

Interviewee: Casey Schreiner
Date / Time: January 9, 2017 / 1300 Pacific standard time (PST)¹
Location: Southern California Terminal Radar Approach Control (SCT TRACON)
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Mr. Schreiner stated the following:

Mr. Casey Schreiner began working with the FAA in August of 1998 as a direct hire to High Desert Terminal Radar Approach Control facility (E10 TRACON), Edwards Air Force Base, California. He worked there until April of 2000 when he transferred to SCT. Mr. Schreiner was a controller in the San Diego area until January of 2010 and was qualified on all positions. In January of 2010, he became a front line manager (FLM) at SCT in the Burbank area. Mr. Schreiner became the supervisor of the traffic management unit (STMC) in January of 2016. His second-class medical certificate was current with no restrictions. He did not have any other airman certificates and was certified on all positions in the traffic management unit.

Mr. Schreiner worked a 1400 to 2200 overtime shift on the day of the incident; he added that he stayed until 2300 to do the traffic situation report. He was routinely scheduled overtime about once every two weeks because the facility was understaffed with supervisors.

Mr. Schreiner remembered that despite weather in the area all morning, that by the time he arrived at 1400, it seemed like a “routine evening.” There was a west operation for Los Angeles International airport (LAX) planned with light east winds; LAX had a waiver to stay on a west operation with wind less than 10 knots. Based on data from the flight schedule monitor (FSM) and the traffic situation display (TSD)², SCT was going to remain busy until 2300. Mr. Schreiner felt that with the east winds, and LAX tower calling to coordinate opposite direction departures because of the winds, that he should stay until 2300. He would help with coordinating these issues with the sectors at around 2200 as SCT began to combine positions in preparation for the mid-shift operation. The STMC was required to stay until all traffic management initiatives were cancelled. When the operations manager in charge (OMIC) arrived for the mid-shift, Mr. Schreiner approached him in the arrivals area to advise him and all the controllers working, of the planned opposite direction departures from runway 7. Afterwards, the OMIC went to the Burbank area to work. Mr. Schreiner left the TRACON around 2300 and there was no indication that any sector was going to get busy with traffic. The STMC had asked for an Airport Surface Detection Equipment, Model X (ASDE-X)³ display of LAX so they could see their departures begin to line up, but instead got a system wide information management system (SWIM)⁴.

¹ All times Pacific standard time unless otherwise noted.

² A tool used to predict, on national and local scales, traffic surges, gaps, and volume based on current and anticipated airborne aircraft.

³ A surveillance system using radar, multilateration and satellite technology that allows air traffic controllers to track surface movement of aircraft and vehicles

⁴ A Federal Aviation Administration (FAA) advanced technology program designed to facilitate greater sharing of Air Traffic Management (ATM) system information, such as airport operational status, weather information, flight data, status of special use airspace, and National Airspace System (NAS) restrictions.

Mr. Schreiner became aware of the EVA015 incident the next day. He was told that LAX went to an east operation, which did not surprise him because of the wind. SCT operated “west traffic” or “over water” 99% of the time, and when LAX switched to east traffic no one considered the minimum vectoring altitudes (MVAs)⁵. Mr. Schreiner felt that facility training was not good for east traffic operations, and that there was a reluctance to switch to east traffic, usually waiting until the last minute to do so.

Routinely, departure traffic was busy between 2300 and 0100, and he had long been concerned about how late the traffic would run into the night when the mid-shift came in. Mr. Schreiner said that supervisors had no influence on controller breaks during the mid-shift since they were usually not qualified in the areas, so the controllers just did their own thing.

Overall the relationship between the National Air Traffic Controllers Association (NATCA)⁶ and facility management in the facility was good. However, the Del Ray operational area and management seemed to have a more strained relationship.

Interview concluded at 1430 PST.

Interviewee: JulieAnn Peterson
Date / Time: January 9, 2017 / 1500
Location: SCT TRACON
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Ms. Peterson stated the following:

Ms. JulieAnn Peterson began working with the FAA in October of 1989 reporting to the FAA training facility, Oklahoma City, Oklahoma. After completing the ATC basic class, she reported to the tower training program for follow on training. After completing tower training in March of 1990, she reported to San Gabriel Valley Airport (EMT) air traffic control tower (ATCT), El Monte, California. In March of 1991, Ms. Peterson transferred to Burbank ATCT (BUR ATCT), Burbank, California, and in September of 1993 transferred to Ontario terminal radar approach control (O40 TRACON), Ontario, California. She remained at O40 until the facility was consolidated into the current SCT configuration.

Ms. Peterson was the SCT QC support specialist and maintained 8 hours per month in the traffic management unit (TMU)⁷ to keep her operational currency; she was designated a controller in charge (CIC) in the TMU unit. Her regular days off (RDOs) were Saturday and Sunday and her

⁵ Minimum Vectoring Altitude (MVA) is the lowest altitude, expressed in feet MSL (Mean Sea Level), to which a radar controller may issue aircraft altitude clearances during vectoring/direct routing except if otherwise authorized for radar approaches, departures and missed approaches.

⁶ The labor union that is the exclusive bargaining representative for FAA air traffic controllers.

⁷ The entity in ARTCCs and designated terminals directly involved in the active management of facility traffic..

work schedule was Monday through Friday from 0600 until 1400; she routinely worked extra hours charging them to credit hours. She was a private pilot who had not exercised her pilot privileges since 1996. Ms. Peterson maintained a current second class medical certificate with a requirement to wear glasses in the performance of her duties.

Ms. Peterson first became familiar with the incident shortly after arriving to work on December 16, 2016. She began reviewing the previous watch mandatory occurrence reports (MORs)⁸, and getting caught up with emails. Operations manager (OM) Mark Kuck had sent her an email with a Falcon plot replay⁹ attached. She watched the replay, and before it had completed, she took out the show plot function as a “spoiler alert” so she would know EVA015 had made it out of the mountainous terrain near Mt. Wilson before continuing to watch the rest of the replay. She was very surprised at what she had seen on the replay.

Ms. Peterson felt the incident should have automatically triggered a services rendered telcon (SRT)¹⁰. She began to prepare the briefing for the SRT by assembling all the pertinent data. Later that morning, Ms. Peterson was advised by Mr. Karpe that there would not be an SRT. She believed Mr. Karpe and the FLM had been looking at the wrong MVA map associated with the Falcon replay rather than using the correct “fusion 3-mile MVA map.” Consequently, the incident did not look as bad as it would have with the correct MVA map. Ms. Peterson believed the OM knew that this incident was significant; however, she believed that the facility was advised by the service area that the significant MOR was not required. Ms. Peterson believed the service area was looking at the emergency operations vectoring map (EOVM)¹¹ and not the MVA map, and that was why the WSA QC did not think it was significant. The MOR was eventually completed by Mark Kuck on December 16, 2016 and was marked significant.

After reviewing the incident, Ms. Peterson was concerned with the performance of the controller, controller utilization of available maps, data block management, amount of time on position, fatigue, and the amount of overtime being worked by controllers. The facility had looked at a previous loss of separation incident involving the same controller back in 2015.

As three LAX arrivals had executed go-arounds because of wind, the incident controller began holding the aircraft over Santa Catalina Island to give LAX ATCT time to change from a west flow to an east flow. Ms. Peterson said there had also been at least one divert involving a Southwest Airlines aircraft for a tailwind along with two other divers for unknown reasons. The incident controller had been working double the number of aircraft that the sector normally worked at that time of the morning.

Ms. Peterson had watched the video replay with Mr. Karpe and the OM. Originally, there had not been an SRT scheduled, and after viewing the replay, Mr. Karpe instructed Ms. Peterson

⁸ An occurrence involving air traffic services for which the collection of associated safety-related data and conditions is mandatory.

⁹ A tool that would playback track data from the radar system.

¹⁰ 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.

¹¹ The EOVM is intended to facilitate advisory service to an aircraft in an emergency situation wherein an appropriate terrain/obstacle clearance minimum altitude cannot be maintained.

to “stand down” her research into preparing for an SRT, that an SRT would not be conducted. Since the facility was not completing an SRT, they would start a System Service Review (SSR)¹². The facility delegated that responsibility out to the local safety council (LSC)¹³ and personnel from the Del Ray area. Ms. Peterson thought those persons assigned to the SSR had been given time off from the operation to complete the SSR as quickly as possible. After she had seen the completed SSR, Ms. Peterson thought it may have been rushed. The SSR team had not been able to interview the incident controller because she had been out on Office of Worker's Compensation Programs (OWCP) trauma leave as a result of the incident.

On Monday, December 20, 2016, an SRT was scheduled and completed and Ms. Peterson had participated. The SRT had consisted of a pre-brief with district management, followed by a detailed brief to WSA QA/QC, and national FAA personnel. The ATM had gone through a detailed synopsis of the incident followed by an unofficial transcript provided by Ms. Peterson. The facility played the audio and radar playback, discussed employee schedules, FLM experience, controller performance history, and other operational incidents that had occurred on the mid-shift.

Ms. Peterson said that SCT had been on an east operation with LAX about six times over the period of a year. This resulted in a low frequency, high-risk operation. She considered any incident involving an east flow to be a significant incident because they were on an east flow so infrequently.

Interview concluded at 1630.

Interviewee: Steven J. Thompson
Date / Time: January 10, 2017 / 0830
Location: SCT
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Mr. Thompson stated the following:

Steven J. Thompson began working for the FAA in May of 1988 when he reported to the FAA training facility, Oklahoma City, Oklahoma. After successfully completing initial training in August of 1988, he reported to Chicago Air Route Traffic Control Center (ZAU ARTCC), Chicago, Illinois. In January of 1990, he transferred to Minneapolis ARTCC (ZMP), Minneapolis Minnesota, and in March of 1991, he transferred to Grand Forks International Airport (GFK) ATCT, Grand Forks, North Dakota. In January of 1997, he transferred to Evansville Regional Airport (EVV) ATCT, Evansville, Indiana, and in March of 2001, Mr. Thompson transferred to Phoenix TRACON (P50), Phoenix, Arizona. In September of 2009, he was promoted to FLM. In June of 2016, Mr. Thompson was selected as an FLM at SCT.

¹² An SSR is to review the air traffic services provided in any situation at any time under any circumstances.

¹³ A collaborative team comprised of at least one union representative and one management representative.

Mr. Thompson maintained a current second class medical certificate with no restrictions. At the time of the incident, his RDOs were Friday and Saturday. Mr. Thompson regularly worked six days a week due to lack of FLM staffing at SCT. Of the last 17 weeks leading up to the incident, 15 weeks included six-day work weeks. He preferred to work the “swing shift” for his overtime day; however, on the day of the incident, he had worked a 0600 to 1400 shift followed by an overtime mid-shift from 2200 later that evening to 0600 the following morning.

There was one shift assigned at 1515 to 2315 available for holdover staffing if needed. If the LAX operation was going to be busy, the FLMs of the LAX arrival area and Del Ray areas would normally holdover to meet the demand. On the mid-shifts, the areas usually ran themselves and Mr. Thompson did not assign breaks during a mid-shift. In the LAX arrivals area, when the mid shift personnel get to work, they would immediately relieve the two controllers working the arrivals to LAX and combine each with another feeder control position. As soon as traffic permitted, they would combine down to one controller working the area and the other controller would go on a break

Mr. Thompson had arrived at SCT the evening of December 15, 2016 and immediately went to work, feeling very good and energized. He had not spoken with the OMIC; however, because LAX was on a west flow, there were several pilots requesting opposite direction departures due to tailwinds. From 2230 to about 0000, they had several go-arounds due to the winds. Mr. Thompson had requested on numerous occasions that LAX ATCT consider a runway change to east flow.

During this time, Mr. Thompson did not recall being briefed by the STMC of any significant issues for the watch. Mr. Thompson said he was not aware of a formal procedure for the STMC/TMC to brief the OMIC before they leave for the evening. The OM he relieved left before midnight, and sometime around midnight, LAX went to an east flow. Mr. Thompson heard one of the Del Ray area mid-shift controllers combine up the operational positions to the Manhattan position and told the on-position controller to call him if she needed him.

To see if LAX was going to be busy with a departure or arrival rush, Mr. Thompson would monitor a large computer screen that provided departure information. Arrival information was obtained from the TSD monitor which nationally, showed all arrivals into LAX. After 0000, traffic was a routine east flow with a fair amount of traffic. By 0045, traffic was “dying down”.

Mr. Thompson first became aware of the EVA015 incident when he heard the Manhattan controller talking loudly and using an explicative between transmissions. Everyone in the radar room knew something was going on. Ms. Hocutt was not very busy according to Mr. Thompson. She was responsible for four aircraft on her radar display with two of the aircraft already switched to another control position and no longer on her frequency. He noticed two aircraft data blocks were overlapped on her display.

Because of the commotion, he walked over to the Manhattan sector in the Del Ray area and heard Ms. Hocutt giving instructions that were confusing to the pilot of EVA015. Mr. Thompson believed he was involved as much as he could be, but did not want to tell Ms. Hocutt what to do since he was not certified in the Del Ray area. He did not hear Ms. Hocutt give EVA015

the initial left turn heading to 180°. Mr. Thompson went over to the Burbank sector controller to advise him of EVA015 going northbound, the Burbank sector controller was already aware. He heard the Burbank controller yell over to Ms. Hocutt to “climb EVA”.

Mr. Thompson had not observed the Del Ray controller use the EOVM or the MVA map on her radar display during the incident. He had not remembered seeing or hearing the “low altitude alert” activate on the display. Mr. Thompson had never issued a “low altitude alert” in his career, but was aware of the phraseology associated. He did not know that the MVA was an issue when the incident occurred, and that was why he had not submitted an MOR.

At the time the incident occurred, Ms. Hocutt had been on position about three hours and fifteen minutes. The controller did not request, nor was she offered a break following this incident following this incident but did request to see the Falcon replay of the incident; Ms. Hocutt was not happy after she reviewed the replay. Mr. Thompson had not talked to the Burbank controller after the incident occurred.

Mr. Thompson had previously put MORs into CEDAR but said that he had never started a draft MOR and saved it for later. He could not find the correct MVA map in Falcon because of the way the maps were labeled in the system. Mr. Thompson knew that Mark Kuck, the Del Ray area OM, would be coming in to relieve him, so he provided Mr. Kuck with all the data to investigate the incident because he would know what to do.

Mr. Thompson had not had an opportunity to work with the controller involved in the incident and was unaware of any performance issues she may or may not have. He had no formal training to act as the OMIC other than a couple of training mid-shifts but felt that training of the sort would not be a waste of time.

Mr. Thompson had received the annual fall refresher training for east flow operations including classroom and simulations. He felt that no amount of training was going to prepare controllers for an east flow operation because it occurred so infrequently, about 20 times per year. When LAX did go to an east flow, he would staff all the sector operating positions in the area and would have controllers rotate to each position for a limited amount of time. This would spread out the experience for each sector position involved.

Mr. Thompson had not received the required annual FLM/CIC training and said that he had never heard of it.

Mr. Thompson believed the event review committee (ERC)¹⁴ was very inconsistent with assignment of skill enhancement training (SET)¹⁵. When it was approved, it was either severely watered down or non-existent altogether.

¹⁴ A three-member group comprising representatives from each party to the respective VSRP non-punitive safety-reporting program. The ERC reviews and analyzes submitted confidential reports to determine acceptability of the report under the VSRP requirements, to identify actual or potential safety problems of accepted reports, and to ensure the appropriate follow-up action is taken and implemented for resolution when appropriate.

¹⁵ Individually focused education and training designed to address an identified qualification issue of an employee in a skill or task.

When asked about the relationship with between facility management and the controllers, Mr. Thompson said it was very good. He could not elaborate about the relationship between the management of the Del Ray area and controllers but felt overall it was not too bad.

Interview concluded at 1000.

Interviewee: Barry Davis
Date / Time: January 10, 2017 / 1100
Location: SCT TRACON
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Mr. Davis said the following:

Mr. Barry Davis began with the FAA in April of 1984 and reported to the FAA training facility, Oklahoma City Oklahoma. After completing the training facility in July of 1984, he reported to Atlanta ARTCC (ZTL), Atlanta, Georgia. In August of 1988, he transferred to Oakland ARTCC (ZOA), Oakland, California. In December of 1999, Mr. Davis transferred to the western pacific region and in August of 2006 transferred to the WSA. In December of 2009, Mr. Davis transferred to SCT as the support manager, and in February of 2011, he was promoted to air traffic manager. Mr. Davis did not maintain a current medical certificate and was not required to. He did not hold any other aeronautical licenses.

Mr. Davis first became aware of the EVA015 incident on the morning of December 16 at around 0500 or 0600 when he received phone call from the OM, Mark Kuck. Mr. Kuck advised Mr. Davis that there was an incident that was reported to him by the OMIC Mr. Thompson. Mr. Kuck and Mr. Thompson reviewed the Falcon replay and initially had difficulty locating the MVA map. This was due to how the maps were labeled. Mr. Kuck and Mr. Thompson eventually located the correct map, and after reviewing the incident determined it was “very ugly.” Mr. Davis was certain the facility understood the significance of the incident.

Based on what Mr. Davis had seen on the replay, the facility prepared for an SRT to upward report the event. Mr. Davis had been “traumatized” by what he had seen on the replay. He contacted District Manager Bill Washington and the assistant terminal district manager staff advisor informing them of the incident, and that it was “very ugly.” Mr. Davis was certain, Mr. Kuck had been in contact with the WSA QCG, but was not sure what data the WSA had requested.

SCT assembled a team and began to look for factors associated with the incident to include weather, complexity, and performance issues. Mr. Davis’ “gut reaction” was that this was a low altitude alert issue. SCT had been starting to see a trend where air traffic was flying later into the night and morning. The SCT support specialist Ms. Peterson had briefed Mr. Davis early on Friday morning that based on the information she had from WSA, there would not be an SRT. The facility believed there would eventually be an SRT, and ultimately a visit by NTSB so they began to get

the required data. The facility continued investigative activities and developed mitigation efforts throughout the day on December 16. These efforts were developed in conjunction with Mr. Davis, the staff manager, traffic management officer, supervisors committee (SUPCOM)¹⁶ chair, training department, OSG, QC department, and the LSC.

Because of the significance of the incident, Mr. Davis felt there was a need to quickly conduct the SSR and have it completed before Monday. When the SRT was eventually scheduled for Monday, Mr. Davis requested the SSR be reopened and the facility would take time to complete it slowly.

Mr. Davis was concerned there had not been two air traffic controllers in the radar room when the traffic complexity picked up, and on Monday morning, Mr. Davis put out facility guidance to keep two controllers in the LAX arrival and departure areas until 2300. The facility had also received guidance from FAA headquarters about fatigue mitigation. Mr. Davis initiated dialogue with the NATCA facility representative on how to address this issue with the workforce.

Controllers on the mid-shifts usually managed themselves and would typically set their own breaks and rotations on position. The OMIC did not get involved in this process unless they were an FLM that was certified to work in that specific area. According to Mr. Davis, the OMIC was responsible for the breaks and position rotations in the TRACON, but that did not occur. Mr. Davis said that he relied on the next level supervisors to ensure that the FLMs were operating correctly. He had not been aware that the OMICs were not managing controllers on the mid shift and that it had “not been on my radar.” The SCT FLMs would undergo FLM training which included training on how to work as an OMIC. Mr. Davis said that FLM refresher training was conducted in the first quarter of each fiscal year as required by FAA Order 3120.4. He believed the CICs were receiving the refresher training but did not believe the FLMs were getting that training.

On January 5, 2017, the facility met with QA from the command center, district representatives, LAX ATCT, LA ARTCC, NATCA representatives, TMOs, representatives from Southwest Airlines, United Airlines, Delta Air Lines, and American Airlines at LAX for a meeting to discuss the flow of traffic and airport capacity. The meeting discussed users of the south side of the airport not having enough gates to put aircraft into after arriving at the airport. In some cases, there was so much traffic there would be two or three aircraft waiting to utilize a gate. This caused traffic to back up into the air resulting in holds. Every day, SCT was running a ground delay program (GDP) to decrease the amount of arrivals to gates and facilitate more fluid movement of traffic. A decision was made to expand the scope of the GDP to include traffic departing Chicago and New York, and to explore an option to target a GDP to just those specific carriers that utilized the south side complex. This meeting was not mandated because of this incident, but because of incidents that occurred on December 21 and 23, 2016 when the airport was almost gridlocked because of the volume of traffic on the airport. The meeting also discussed the upcoming runway closure, and the number of operations that were extending into the evening.

Interview concluded at 1245.

¹⁶ The purpose of the SUPCOM is to maintain open communication with operations supervisors by facility/HUB/district, service area and national Air Traffic Organization (ATO) management.

Interviewee: Sherika N. Hocutt
Date / Time: January 10, 2017 / 1430
Location: SCT TRACON
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Joel Ortiz

During the interview Ms. Hocutt said the following:

Sherika N. Hocutt began her career with the FAA in April of 2007 as a direct hire into the FAA. She reported to Southwest Florida International Airport (RSW), Fort Myers, Florida in April of 2007 and in May of 2009 she transferred to Fayetteville Regional Airport/Grannis Field (FAY), Fayetteville, North Carolina. In December of 2012, she transferred to SCT. She was fully certified in the Del Ray area of SCT. Her prior ATC experience was in the United States Navy from July of 2000 to July of 2005 stationed at Fleet Area Control and Surveillance Facility (FACSFAC) Virginia Capes (VACAPES), Virginia Beach, Virginia.

Ms. Hocutt did not hold any pilot ratings and held a current second class medical certificate with no restrictions. At the time of the incident, her RDOs were Wednesday, Thursday, and Friday. She regularly worked 6 days a week due to lack of staffing at SCT. Ms. Hocutt's manager was Brad Bowdish.

On the day of the incident, she had worked a 0545 to 1345 shift followed by an overtime mid-shift starting 8 hours later at 2200 to 0600 the following morning. Ms. Hocutt left work the afternoon prior to the incident; she could not recall exactly what she did, but, said she would normally eat and go to sleep around 1800 and wake up around 2100 to 2110. She lived within 20 minutes of the facility.

When Ms. Hocutt arrived at work at 2200 on the day of the incident, she assumed the Manhattan position in the Del Ray area and Mr. Swinson, her co-worker for the mid-shift, assumed the Malibu position. She reported a storm cell had already pushed through the area and was 20 miles southwest of LAX with another cell just south of LAX moving south and eastbound past Santa Catalina Island. There was a "hole" in between the two cells. The arrival aircraft were coming in over the fix TANDY near the first cell for landing at John Wayne airport. She was working normal traffic, calling weather, and asking pilots if they wanted to deviate around the weather cells. Both departure aircraft and the arrival aircraft were deviating between the storm cells. Because of these deviations, she had called LAX ATCT and placed a departure flow restriction of five miles in trail. Aircraft began to go-around due to weather, and there were opposite direction departure requests that required a 20-mile gap in the arrival aircraft line up. The first opposite direction departure was coordinated by the STMC.

Around 2245, while working normal traffic, Mr. Swinson offered to combine both Del Rey area positions, so Ms. Hocutt could go take quick break and come back to relieve him for a break. The normal operating procedure for mid-shift operations was to divide the shift in half. Mr.

Swinson asked Ms. Hocutt if she would mind working the first half of the mid-shift and he would take the last half; she accommodated that request.

When Ms. Hocutt came back to relieve Mr. Swinson around 2255, Mr. Swinson told her to call him if she needed anything, or, if LAX was going to go to an east flow. After assuming the combined position, there were more LAX opposite direction departure requests and two more LAX go-arounds. The pilots going around indicated they could not land on the runway because of winds, and Ms. Hocutt told the OMIC that she was holding two go-arounds along with an ocean arrival and Mr. Thompson needed to build a hole with LAX ATCT. She sent all three aircraft to Santa Catalina Island to hold. She said that Mr. Thompson was working with LAX ATCT to change to an east flow. She called LAX ATCT to stop departures because several pilots had indicated they were going to divert; that was when LAX ATCT changed to an east flow. That was at about 0000.

After the flow change to the east, traffic was normal for that time of the shift. EVA015 departed LAX and she radar identified the aircraft and instructed the pilot to fly a heading of 090°. An Air Canada flight departed shortly after EVA015. Ms. Hocutt turned EVA015 left to a heading of 180°. She believed that she had said “turn right”, and she moved on to other control responsibilities. By the time she noticed EVA015 turning left, she realized the conflict with the Air Canada flight and just needed somebody stop their climb. She saw Air Canada heading towards EVA015 and quickly began to separate the two aircraft with altitude. Since EVA015 was lower, she told Air Canada to expedite their climb. Ms. Hocutt was frustrated and had a lot going on. LAX ATCT had called her with another go-around and were requesting a heading and altitude to assign. She instructed the LAX ATCT controller to issue a heading of 090° and an altitude of 2,000 feet. She did not realize the heading and altitude would be below the MVA for the go-around. Ms. Hocutt had a lot going on in her mind, thinking she was going to have to request a runway change again due to go-arounds beginning to occur on east flow.

Ms. Hocutt said she was thinking about other duties, still scanning, still working with other aircraft, when she looked back at EVA015 and saw the aircraft was not turning south as instructed. She instructed the pilot of EVA015 to go southbound; she just wanted to get EVA015 out of the Burbank sectors airspace and back into her own airspace. She was not familiar with the MVAs in the Burbank sector because that was not her airspace. Even on an east flow, they are always topping Burbank’s traffic so the MVA did not cross her mind.

Ms. Hocutt did not know why she turned EVA015 left instead of right; she just wanted EVA015 to go southbound. During the incident, she did not know where the OMIC was; however, a maintenance technician had come over and sat beside her. The Burbank controller had yelled over to her and said watch out for the MVAs with EVA015. She said that she knew she needed to be higher with EVA015 when she looked at the MVA map. Everybody in the TRACON heard what was going on because she was talking loudly and using expletives between transmissions.

When she finally got EVA015 turned southbound, the operation became normal. The EMPYR sector controller came down to her and said he probably should have called Mr. Thompson or Mr. Swinson to assist. Ms. Hocutt said the OMIC had never showed up and was not around her during or after the incident. He never came over until she asked him to pull the tapes; Ms. Hocutt felt he should have been there and he was not.

Mr. Thompson queued the replay for her when she was getting ready to be relieved by Mr. Swinson. She was relieved at 0215. Mr. Thompson played the replay and they watched and listened to it together. When Ms. Hocutt heard herself give EVA015 the left turn, she knew it was her mistake. Mr. Thompson suggested Ms. Hocutt file an Air Traffic Safety Action Program (ATSAP)¹⁷ report about the incident. She could not file an ATSAP report after the incident and while on shift because she could not get her password to work. Ms. Hocutt said she filed the ATSAP report sometime on December 17, 2017; more than 24 hours after the incident.

She did not know how bad the terrain separation incident was until she received a call on Saturday asking her if she was alright. It was frustrating, and it devastated her to know she almost killed people.

Ms. Hocutt went on OWCP leave from December 16, 2016 until she was permitted to go back to work January 4, 2017. She returned to work January 7, 2017. She was told she could work the Flight Data position only until the ATSAP event review committee (ERC) plan was received.

Ms. Hocutt was not on any medications and when she got tired on position, she would stand up or push back from the position and she would also drink water. She had received the fatigue mitigation training in electronic Learning Management System (eLMS)¹⁸.

Ms. Hocutt said that the Del Ray area was on a west flow for most of the year and that she had worked east flow operations maybe six times in the past year. On west flow operations, she had always turned the departures left because that was the standard operating procedure. On east flow, a right turn out was utilized and she thought that she must have just defaulted to the left turn as she would normally do.

She said the relationship between the controllers and management in the Del Ray area seemed like they were constantly “butting heads”. One FLM was competent, the others were incompetent.

Interview concluded at 1630.

Interviewee: Mark Swinson
Date / Time: January 11, 2017 / 0900
Location: SCT TRACON
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Joel Ortiz

During the interview Mark Swinson said the following:

¹⁷ A confidential, non-punitive, safety-reporting program for employees in En Route, Terminal, and System Operations. This program is administered by ATO Safety with the participation of NATCA and AOV.

¹⁸ eLMS is the FAA's learning management system.

Mr. Swinson began working with the FAA in September of 1997 as a direct hire to Gillespie Field Airport (SEE) ATCT, San Diego/El Cajon, California. In June of 2000, he transferred to SCT. Mr. Swinson was a controller in the Del Ray area and was qualified on all operating positions. His second-class medical certificate was current with no restrictions. He did not have any other airman certificates.

Mr. Swinson was working a 2200 to 0600 mid-shift on the day of the incident. He remembered that he arrived in the area around 2200 and Ms. Hocutt was working the D1 (Manhattan) sector with Laker, Newport, and Catalina combined. Mr. Swinson took over the Malibu sector; he added this was the normal configuration for that time of the shift. He remembered traffic was light because of the weather and that LAX tower could not provide visual separation so there was one flow coming out of the airport. There had also been a five mile in trail restriction for departures from LAX due to weather. Around 2245, Mr. Swinson combined the Malibu sector to the sectors Ms. Hocutt was working and gave her a break for a few minutes to go to the restroom. Ms. Hocutt returned shortly after and relieved Mr. Swinson to take his recuperative break. Mr. Swinson advised Ms. Hocutt that he would be available if she needed him and if they went "east flow" to call him or have the FLM call him back.

Mr. Swinson returned to the TRACON just after 0200 and noticed they were "east flow." He talked to Ms. Hocutt about why she did not call him and just joked with her. Ms. Hocutt told him about the go-around at LAX and that she thinks she got into the MVA near Burbank and that she needed to file an ATSAP report.

Mr. Swinson assumed the entire Del Ray area from Ms. Hocutt and began working traffic. After about two aircraft landing at LAX, they went back to "west flow." He remembered Mr. Thompson and Ms. Hocutt talking until about 0300 about the incident, and her attempt to file an ATSAP. After 0300 Ms. Hocutt could not figure out her ATSAP password and decided to take a recuperative break. From Mr. Swinson's observation, there was no indication from Ms. Hocutt or Mr. Thompson about how significant the incident was. He was not aware of the significance himself until we woke up after getting off the mid-shift around 1100 and had many texts and emails about the incident. Mr. Swinson called the union facility representative (FACREP), Mr. Ortiz and learned how significant the incident was.

Mr. Swinson said that FLMs were not involved in the mid-shift operation in his area unless something unusual occurred. In the event that something were to happen, Mr. Swinson would expect the FLM to give assistance, make phone calls, etc.

Mr. Swinson was familiar with the MVAs in the Burbank area because he was certified in the EMPIRE area for several years. That area routinely dealt with the MVAs.

He felt that the NATCA and management relationship in the Del Ray area was "as bad as it has ever been." He felt that it was due mainly to one supervisor, Carl Keller. He felt it was a distraction to the normal operations of the area with all the issues that come up because of this supervisor. He felt that the OM Mark Kuck had not addressed the issue.

Mr. Swinson's impression of Ms. Hocutt was that she was a solid controller, fun to work with, always in a good mood, and great to work with. He has never observed her where she couldn't recover from something.

Mr. Swinson felt that LAX normally waited too long to switch flows. He suggested that two people should be in the area until 0200.

Interview concluded at 1030.

Interviewee: Phillip J. Delgado
Date / Time: January 11, 2017 / 1200
Location: SCT TRACON
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Joel Ortiz

During the interview Mr. Delgado said the following:

Phillip J. Delgado began his career with the FAA in July of 2006 as a direct hire. He reported to E10, Edwards Air Force Base, California in July of 2006. In January of 2010, he transferred to SCT, and was fully certified in the LAX Arrival area. Prior to the FAA, Mr. Delgado was employed by the Department of Defense, at the Marine Corps Air Station in Yuma (NYL), Yuma, Arizona from January of 2004 to July of 2006. He had also been in the United States Air Force from January of 2001 to January of 2004 and was stationed at Columbus Air Force Base, Columbus, Mississippi.

Mr. Delgado did not hold any pilot ratings and held a current second class medical certificate with no restrictions. He was qualified on all positions in the LAX Arrival area. At the time of the incident, RDOs were Saturday and Sunday, and his supervisor was Nancy Qusem.

Mr. Delgado and his mid-shift co-worker Alex Cisneros arrived at work at 2200 for the mid-shift and both relieved the other controllers in the area. There were thunderstorms in the area and he knew it was going to be a busy and challenging mid-shift. There were deviations and at least five or six go-arounds due to the winds. The area FLM was trying to get LAX ATCT to go to east flow. Mr. Cisneros was still working the position when the LAX ATCT went to east flow. The controllers held a few aircraft while the turnaround occurred. The two controllers continued to work the traffic until around 0030 when it tapered off. Mr. Cisneros took a break and Mr. Delgado continued to work the area combined to one position.

Mr. Delgado believed the incident occurred a little after 0100 while he was still a little busy. He became aware of incident when he heard Ms. Hocutt talking very loud and having issues with EVA015. He observed EVA015 heading northbound toward Mt. Wilson at 320 knots. He could hear the controller telling EVA015 to turn. He knew Ms. Hocutt had called the Burbank sector for the point out since he had heard the coordination. He thought he was going to see a plane

crash because he was very familiar with the MVAs there. He had his MVA map pulled up watching how close to the mountain EVA015 was.

Right after the incident occurred; Mr. Thompson came around the corner of the area. Mr. Delgado asked him if he saw the incident and Mr. Delgado told him he should take a look at that one. Utilizing the slew ball, Mr. Delgado showed Mr. Thompson on his radar display the track EVA015 took and the relationship of EVA015 to the obstructions depicted on the MVA map. Mr. Delgado believed there was no doubt Mr. Thompson knew the significance of the incident. Mr. Thompson asked Mr. Delgado if he knew the controller very well and he said he knew her but not very well.

Several days after the incident, Mr. Thompson told Mr. Delgado this incident would be a bad one.

Interview concluded at 1300.

Interviewee: Kevin Teare
Date / Time: January 11, 2017 / 1430
Location: SCT TRACON
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Mr. Teare said the following:

Mr. Kevin Teare began with the FAA in January of 1983 and reported to the FAA training facility in Oklahoma City, Oklahoma. In July of 1983, Mr. Teare reported to Coast Approach (CST), El Toro, California until March of 1994 when it was consolidated to SCT. Mr. Teare was a fully certified controller in the Coast area as well as holding various positions such FLM, support specialist for procedures, TMC, STMC, OM, before becoming a Traffic Management Officer (TMO). He did not have a current medical certificate, nor was it required. Mr. Teare's immediate supervisor was Barry Davis.

Mr. Teare's work schedule consisted of Saturday and Sunday RDOs. On the date of the incident, Mr. Teare was working his regular scheduled shift of 0700 to 1530.

On Friday, December 16, 2016, Mr. Teare first became aware of a potential incident on his commute into work while listening to the radio. When he arrived at work, he checked in upstairs and the OM on duty, Mr. Kuck was reviewing the Falcon replay of the incident. Mr. Teare watched the replay and thought it looked "bad." He did not expect to see EVA015 come out of the other side of the mountainous terrain.

Later than morning, Mr. Davis, asked Mr. Teare to conduct a traffic management review (TMR)¹⁹ and to reach out to the air carrier involved in the incident. Mr. Teare sent an email to the carrier. Mr. Teare conducted the TMR and tried to look at how much traffic would have been pushed back later because of the night shift operation and staffing. After reviewing a seven-day history prior to the incident, Mr. Teare concluded that the night of December 15 to December 16 was pretty consistent with the previous week regarding the traffic; he added that between 0100 to 0130 traffic was significantly busier than during previous nights. Mr. Teare was unsure why traffic may have been pushed back later other than the east flow operation. He did not notice any GDP in effect or arrival delays that would have caused this delay.

Mr. Teare said that it was usually a joint effort from LAX ATCT and SCT to turn the airport around to east flow; he added that it was triggered by the wind. They consider opposite direction departures, go-arounds, and wind forecasts, etc. He said they make every effort to stay in a west flow. On occasion, Mr. Teare remembered there were times the TRACON had to force LAX ATCT to switch to east operations; he added, that it was more of an exception rather than the norm. He also added that the TRACON and LAX ATCT would avoid an extra runway change and suffer through the wind, would be preferred.

Mr. Teare said that FLMs were not trained as well on TMC equipment, but every FLM had a workstation with these same tools in their area. He believed that FLMs understood how to interpret the data for their area better than other areas in the TRACON. Mr. Teare had been involved in conversations with Mr. Davis regarding how to make FLM training better. He said that when the TMC left for the night, they had a checklist they were required to use in briefing the OMIC as well as a requirement for it to be recorded.

Mr. Teare felt there was a strained relationship between NATCA and management in the Del Ray area and there had been resentment towards the OM Mark Kuck.

Interview concluded at 1530.

Interviewee: Brian Johnson
Date / Time: January 12, 2017 / 0800
Location: FAA WSA
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Mr. Johnson said the following:

Mr. Brian Johnson began with the FAA in October of 1988 and reported to the FAA's training facility in Oklahoma City, Oklahoma. After graduating in January of 1989, he reported to

¹⁹ The intent of a TMR is to perform an evaluation of service delivery point (SDP) traffic management (TM) operations with a focus on identifying issues that may impact system efficiency.

Theodore Francis Green State Airport (PVD) TRACON, Providence, Rhode Island. In October of 1991, he transferred to Salt Lake TRACON (S56), Salt Lake City, Utah, and in October of 2010, he transferred Portland TRACON (P80), Portland, Oregon. In July of 2013 he transferred to the WSA QA office for duty. His prior military experience was with the the Utah Air National Guard from May of 1986 until October of 1988 where he was an air traffic controller at Hill AFB. Mr. Johnson did not hold a current medical certificate and was not required to for his duties.

Mr. Johnson worked in the WSA QA office and was responsible for the QA validation function for the Southern California District. He reported that 90% of MORs, EORs, and other data they validated was from SCT because of the sheer volume of traffic in Southern California. Mr. Johnson was also responsible to review data from underlying air traffic control towers as well. Mr. Johnson worked the Southern California District with Dale Richards due to the volume; Mr. Johnson worked SCT events on the even days while Mr. Richards worked odd days. SCT was historically a big MOR/EOR numbers generator along with NCT, and as a result, WSA had two QA specialists assigned to SCT and two assigned to NCT. There were times that a third specialist would assist if it became too busy. It was not uncommon for SCT to be 5 to 10 days behind on general EOR/MOR submissions. Mr. Johnson did not believe the FAA was actively enforcing the requirements for MOR reporting. He felt that facilities were reluctant to report because it was not being enforced; no accountability. Most of the risk analysis events (RAEs) for SCT were a result of what WSA detected. The majority of what SCT self-identified was very benign or minor controller or pilot mistakes.

When there was a significant MOR it would go to the top of the MOR list. Most of the significant MOR/EOR events in SCT were detected by the WSA QA office. Many of those MORs included TCAS RA, and loss of separation events with a method of compliance (MOC) below 33%. There were times SCT would report a TCAS RA, but omit the fact that the controller put the two aircraft in conflict. It was Mr. Johnson's opinion that SCT was doing the bare minimum with respect to reporting MORs. This made it difficult for the QA specialist because they were required to assemble so much more data on their own without the local facility assistance. He described an event where an MOR was submitted on a temporary flight restriction (TFR) violator for SCT. Mr. Johnson contacted SCT and requested the TFR information from SCT; they provided Mr. Johnson the TFR details. He asked SCT if they issued a brasher warning to the pilot; they had not. Mr. Johnson said that was something that occurred on a regular basis with the QC at SCT. At SCT they issue more PDs to general aviation pilots than they do to the airlines. Mr. Johnson had heard there was a culture at SCT and LAX ATCT that they did not want airline pilots to lose their jobs

Mr. Johnson described the quality of the MOR submissions by SCT as poor by saying 75% of the time, or more, the MORs submitted by SCT needed a lot more work. As a result, he felt more like an investigator and not a validator because of the required efforts to get information.

Mr. Johnson described the EVA015 incident from the QA perspective. He said the incident was over a four-day weekend for him and that he came in to work behind the power curve. As soon as he came in to work on December 20, 2016, he saw that SCT had submitted a significant MOR. He pulled it out of the queue and began the validation. Mr. Johnson felt that because of how close the aircraft was to terrain, SCT had more accurately reported this MOR than past MORs. When it was a bad incident, SCT did a decent job checking the boxes and marking the incident

significant. It was incidents that were not quite as bad that SCT lacked accurate reporting. The emphasis on significant events was not so much for the QA group to come to a quick conclusion, but rather, for the MOR to get acted upon quickly. Mr. Johnson did not change the way he validated incidents based on the significance of the MOR.

Validation of the EVA015 incident was no different regardless of whether it was marked significant by the facility by QA; Mr. Johnson's write up of the incident would not be different. On an MOR, the submitter could identify and discuss information but could not discuss individual performance. The only thing that he would have done different if SCT had not marked the MOR significant, was that he would have called the ROC and let them know they had a significant event from SCT.

The MOR draft button was created so the submitter could enter the MOR, review it for accuracy, add data, etc., and then submit it later. Mr. Johnson said that it did not surprise him that the MOR was not submitted until later December 16, 2016. It did not surprise him either that the FLM did not start or do the MOR. It was Mr. Johnson's professional opinion SCT had a different level, or, higher tolerance for risk.

LAX ATCT was also in Mr. Johnson's area of responsibility. He said that LAX was good at reporting surface events, touching down without landing clearance, crossing hold lines, etc. SCT and LAX ATCT were very sensitive toward VFR aircraft touching class B airspace. Mr. Johnson said that LAX ATCT did not do as good a job reporting "controller mistakes."

Mr. Johnson had been working SCT events since mid-2013. He added that because of validations and developing trend data, he sent a lot of trend information over to the QCG. There was no formal process to send information between QA and QC. Mr. Johnson believed they should spend more time observing through an operational skills assessment (OSA)²⁰ rather than spending all of the time conducting investigative activities. This was hard to do with the amount of work that was being generated. Additionally, the QA specialists did not put as much attention in validations and investigations because they do not have the time.

Mr. Johnson felt NCT had an amazing, very aggressive, QC process. When WSA called NCT, they were very receptive, etc. QCG would rarely get involved because NCT was so proactive.

The relationship between SCT and WSA QA was not cooperative or friendly. There was a lot of friction and tense relationships between WSA and SCT. Mr. Johnson also said there was a tense relationship with WSA QCG because of SCT. When Mr. Johnson would validate an event and find trends, he would put together examples, makes Falcon bookmark links, and send the information over to the QCG. Generally, he would never get a response from the QCG. Mr. Johnson heard that when he sent information about trends over to the QCG, it apparently upset people because they thought Mr. Johnson was assigning work. Mr. Johnson felt he was only sharing what he was observing.

²⁰ OSAs are supplemental tools for IPM, used by the employee's direct supervisor to improve overall employee performance in those instances when an on-going performance deficiency is identified and documented. OSAs may be conducted via direct or remote monitoring, live observation and via review of playback tools.

Mr. Johnson said the vast majority of EORs that come into the QA office were in the 70% or above MOC. These incidents were not researched and were placed into a deferred file. In his opinion, those were some of the worst incidents, where most of the threat in the system resided. Most of these were not being looked at unless it was also in an MOR. CEDAR was an amazing tool but was inadequate in those “grey area” incidents that were not clear. He believed CEDAR needed an overhaul to make it more functional.

Mr. Johnson felt that a big part of the problem was that SCT had a culture that accepted risk. He did not believe SCT was doing it deviously or with harmful intent. He believed it was a cultural issue. SCT led the district in high risk events and the amount of OSAs that were listed exemplary.

There were several issues that had affected the QA/QC process. Mr. Johnson felt that the FAA had “completely lost grips with performance management.” It was his opinion that in the new QA/QC process, ATO had taken out the ability for performance management. He also believed FLMs were not experienced and that because the FAA did away with the supervisor pay increases, the experience level of supervisors was low in some of the more difficult facilities. He felt that either FLMs did not want, or, did not have the time to do Individual Performance Management (IPM)²¹. Rather than correct the issue, the FLMs avoided conducting IPM. It had been reported that FLMs would just not put controllers on position that were having performance issues, rather than correcting the problem.

Mr. Johnson had made several requests for ATSAP data; however, QA was not entitled to receive it. As a QA validator, Mr. Johnson could request ATSAP data but was not able to see ATSAP data; he could only ask if a report had been filed. Mr. Johnson had not made a recent request for ATSAP data because he knew it would not be approved.

Interview concluded at 1000.

Interviewee: William Hannan
Date / Time: January 12, 2017 / 1030
Location: FAA WSA
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview William Hannan said the following:

Mr. Hannan began his career with the FAA as a direct hire to Luis Munoz Marin International Airport (SJU) ATCT, San Juan, Puerto Rico in May of 1997. In March of 2000, he transferred to Savannah/Hilton Head International Airport (SAV) ATCT, Savannah, Georgia; and in March of 2003, Mr. Hannan transferred to Seattle TRACON (S46), Seattle, Washington. He

²¹ Individual Performance Management (IPM) is a key component in reinforcing optimal performance practices and techniques, as well as identifying and correcting potential performance issues.

transferred to Honolulu Control Facility (HCF), Honolulu, Hawaii in March of 2012; and in January of 2015 he transferred to the WSA. Prior to the FAA, Mr. Hannan was a Collegiate Training Initiative (CTI)²² graduate of Beaver Community College. After he graduated from college, Mr. Hannan worked in a federal contract tower at the Gainesville Regional Airport (GNV), Gainesville, Florida. He held a private pilot rating single engine land.

Mr. Hannan felt ATSAP was the number one problem in QA/QC and that the program was not working. The ATSAP yearly newsletter was about one page and not informative. He did not feel the data coming back from ATSAP reports to facilities were coming back in a useable form.

Based on trend reports from QA, Mr. Hannan would talk to the reported facility to learn more about what was happening. As an example, when QA identified SCT was having MVA violations going into SAN airport. QC took the data from QA, reviewed it, and worked with the district and the facility to mitigate the issue. Ultimately, the district came down and asked SCT to cease and desist descending aircraft when they were past the obstruction on the descent into SAN.

Mr. Hannan said that it had always been hard to get SCT to respond back to requests made by the QC office. Most of his communication was through Mr. Davis or Mr. Karpe. It was Mr. Hannan's practice to keep the air traffic managers in the loop as well as the district office. Mr. Hannan felt that SCT had not done a good job to correct identified issues. One example was the Miramar and Montgomery airport departures. The QC department addressed those issues and obtained clarification from headquarters that the issue was non-compliant. However, SCT continued to do what was non-compliant.

Mr. Hannan felt the quality of the MORs that came out of SCT was poor; they were vague and sometimes did not capture everything that needed to be captured. He felt they were reporting what they were seeing so they follow the order, but did not capture all the details. As a QC specialist Mr. Hannan said that they never tell a facility to redo an MOR, but they would have facilities add data to it in order to capture everything that needed to be captured. He did not understand why SCT could not mark an MOR significant without notifying the manager or district ahead of time. He felt if they had a question about whether it was significant they could always ask QC. He felt the original SSR regarding the EVA015 incident was not robust and did not capture all the issues so he had SCT re-open it.

Mr. Hannan felt that NCT had a more robust QC program than SCT; they had more buy-in from OMs. He felt that NCT OMs were more uniform in their opinions than the OMs at SCT. NCT had a good QC process of identifying trends and reporting them. Mr. Hannan thought that SCT cut corners and perhaps that was why they had more Risk Analysis Event (RAE)²³ than other facilities. The facility knew that QC was looking for certain things, but they continued to do it.

Mr. Hannan said one of the responsibilities of QC was conducting external compliance verifications (ECVs)²⁴. Mr. Hannan was only aware of one with SCT. He had specifically done

²² A network of partnerships with educational institutions to prepare students to pursue their goal of a career in aviation with the FAA.

²³ RAEs are loss of standard separation occurrences that have a MOC of less than 66%.

²⁴ ECVs are assessments of service delivery points (SDPs) that are conducted on an as needed basis as determined

approximately 30 ECVs of different facilities since March and had traveled on all of them. He felt due to funding there were probably not that many ECVs in 2015, but there had been a sharp increase in 2016. He remembered that there were never more than 40 or 50 items on an ECV. When asked about the SCT ECV with only one item, Mr. Hannan said that they were told to stand down because the QC team was there for a corrective action plan (CAP) follow up and not an ECV.

Mr. Hannan said that there were personality conflicts with some people in the QA office. He did not think that QA sending trend data was considered assigning work. He understood that was QAs job and expected that. Mr. Hannan wished that QA and QC were in the same building and wished that QC had the ability to affect change.

Interview concluded at 1200.

Interviewee: Brian J. Johnson
Date / Time: January 12, 2017 / 1330
Location: FAA WSA
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Brian J. Johnson said the following:

Brian J. Johnson began his career with the FAA in December of 1989 starting at the FAA training facility in Oklahoma City, Oklahoma. His first duty station was Salt Lake Center (ZSC), Salt Lake City, Utah from March of 1990 to April to 2009. He then went to the WSA in April of 2009 where he worked for the safety assurance group until February of 2012 when he was promoted to the north team manager at the QCG. Prior to his employment with the FAA, Mr. Johnson served in the United States Air Force at Castle Air Force Base from December of 1981 until July of 1989. Mr. Johnson did not require a medical certificate nor did he hold any pilot certificates. Mr. Johnson worked Monday through Friday and his manager was Mr. Ramirez.

Mr. Johnson was notified of the incident through CEDAR (automated email) at 0759 on December 16, 2016. He forwarded this email to his three specialists for them to review and report back. Normally, SCT would call his department with a significant event like this.

At 0815 on December 16, Craig Powers, one of Mr. Johnson's employees, was called by the SCT OM to advise him of the significance of the incident. Mr. Powers listened and watched the playback. Within an hour, he called compliance service group (CSG) at headquarters and

by the service unit, director of operations, and/or the QCG (with the concurrence of the director of operations). Determinations to conduct ECVs will be based on data analysis that identifies potential risk within specific SDPs. ECVs may be conducted through various methods that may include developing a custom checklist, review of available data (CEDAR quality control and quality assurance data, Risk Analysis Event analysis, information from ATSAP, etc.), direct observation, interviews with personnel, and other means as appropriate.

briefed the specialist on duty; Mr. Howard Burnette determined that the incident was not that serious.

On December 19, Mr. Johnson visited with Mr. Powers and suggested that he should not have let Mr. Burnette off the phone without driving home the significance of the incident and suggesting the need for an SRT.

There had been a disconnect between the WSA QCG and CSG in headquarters coming to the same decision on events. Mr. Johnson said on several occasions, they would expect an SRT to occur on events and CSG would determine that an SRT was not necessary. He believed that his specialists were talking but were not communicating. He suggested that his people should be more forceful and relay their expectation with more vigor.

Mr. Johnson said Mr. Powers met his reporting requirement with his upward report of the incident to CSG. Mr. Burnette had told him clearly that they were not going to do anything with this incident. Mr. Powers had made it clear to Mr. Burnette the significance of this incident but the “bells and whistles” just did not go off.

Mr. Johnson was aware that SCT was working on an SSR and a Traffic Management Review (TMR)²⁵ and wanted to go down to help them. He was told to “stand down” that the central service area was going to assist. He said his department looked at the completed SSR and did a “scrub” of it. He reached out to the district and the facility to make the SSR more robust and gave them suggestions of their expectations concerning the details of this incident. SCT did reopen the SSR and made the necessary additions. Mr. Johnson and his staff looked at the TMR as well, it had been completed by one person, the TMO. It was not as robust as the revised SSR. They felt the time spent on the SSR was inadequate and could be increased and communicated this back to SCT.

Mr. Johnson felt the TMR expressed no “ownership” of the weather issues that existed at the time of the incident, and that the STMC should have had more culpability. He believed that there was not much shared accountability between the SSR and TMR from the facility.

Mr. Johnson felt that all facilities had issues with submitting quality MORs in the early implementation of the QA/QC process. He did not recall QA coming to him with complaints about the MORs SCT was submitting. He also said that a systemic issue with SCT submitting MORs had never been brought to his attention.

Mr. Johnson said there were different requirements for reporting MORs. He said that SCT reported the incident MOR to the ROC and sent the MOR later that morning. He said SCT did struggle with reporting significant events but said other facilities do as well due to lack of training. New members of the group should be getting training on the recently signed QC SOP, but he did not know if the existing members of his group had been trained.

²⁵ The intent of a TMR is to perform an evaluation of service delivery points traffic management operations with a focus on identifying issues that may impact system efficiency.

The amount of ECVs that his group had completed in 2015 was around 40 plus. In 2016, 54 ECVs were accomplished including 12 desk audits. The number of ECVs accomplished during fiscal years 2012 through 2014 was around 94 plus approximately 30 site visits. There were three facilities in the WSA, Alaska, Hawaii and SCT, that had a “culture” issue. He was appalled at SCT for their failure to call traffic to IFR/VFR aircraft. We are too busy to mess with that. He believed this may be caused by a generation gap in which young controllers had an indifference towards the established experienced controllers. He was not aware that SCT FLMs had not received any required FLM/CIC refresher training but said they would have caught that during an ECV. They were trying to capture as much as they could; they wanted to address trends.

Mr. Johnson said they target items on ECVs. The QC office could not thoroughly cover the entire check list. He said that they were the only service center looking at performance record of conference (PRCs) to find a correlation between the PRC, and what was being accomplished to monitor progress.

Mr. Johnson said there was a lot to be said for ATSAP; traffic analysis and review program (TARP)²⁶ had changed the game. Reporting through CEDAR was required. Protective provisions of the voluntary safety reporting systems and occurrence reporting should only be provided if controllers met the submission time requirement. Additionally, Mr. Johnson felt that any FLM should be able to enter a PRC on any employee in CEDAR and that was not currently possible. The 10-day IPM reporting rule needs to be lengthened so facilities could perform the necessary IPM for the controller.

Mr. Johnson had requested ATSAP data and those requests were usually denied initially. His success rate though, was about 90% after he communicated the reason for the data request; for example, class C studies concerning TCAS RAs. When he kept bugging them, they usually gave him the information requested.

Interview concluded at 1530.

Interviewee: Christopher M. Ramirez
Date / Time: January 13, 2017 / 0830
Location: FAA WSA
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Mr. Ramirez said the following:

Christopher M. Ramirez began with the FAA in January of 1992 reporting to the FAA training facility in Oklahoma City, Oklahoma. In May of 1992 he reported to his first duty station at North Las Vegas Airport (VGT) ATCT, Las Vegas, Nevada. In June of 1994, he transferred to McCarran International Airport (LAS) ATCT, Las Vegas, Nevada. In August of 1998, he

²⁶ An automated electronic error detection system. Potential errors are detected and automatically uploaded into Cedar for review by QA and air traffic control facilities.

transferred to Las Vegas TRACON (L30). In January of 2000, he transferred to Hartsfield - Jackson Atlanta International Airport (ATL) ATCT, Atlanta, Georgia tower/TRACON (ATL). In March of 2001 he transferred back to L30. In June of 2007, he transferred to the WSA to work with the OSG. In December of 2015, he was promoted to the QCG group manager position. Mr. Ramirez did not require a current medical certificate nor did he hold any pilot certificates. He worked Monday through Friday and his manager was Clark Desing.

Mr. Ramirez was on two weeks of leave moving when the incident occurred and would check his emails as he could during this time. Mr. Brian J. Johnson was acting on his behalf.

The QCG interfaced with the director of operations of the service area and facility staff. They served as liaison between QA and the facilities in completing/assisting with a facilities compliance of rules and regulations. He was kept up to date on all facilities, and several of those facilities were on his "radar", SCT was one of those facilities.

SCT was very busy and had a CAP in place requiring constant monitoring and tracking. MORs seemed to be an issue with a lack of marking the significant MOR's as significant. SCT could do a better job with this, and his department's oversight could help them accomplish this improvement. Mr. Johnson had communicated his concerns about the quality of SCT's MORs. This issue would drive QCG to include it on the next SCT ECV.

Concerning SCT's completion of SSRs, he had asked the facility to send them to QC for their review prior to forwarding them up the chain. They were not required to do so, but, he had requested it. QCG did not perform ECVs like the eastern or central service areas. Mr. Ramirez would sit down with the directors of the WSA at their request and the directors would add items of interest to the list. They would not take off any items though. After this would occur, the ECV check list would then be sent to the facility in question about two to three weeks in advance of the ECV team's arrival. The last ECV at SCT had one item on the checklist and the QCG manager at that time had since retired.

At the first of the fiscal year, he would meet with his group of specialists and review where the group had conducted ECVs and where they planned to go. He said they would identify the needs of the service area first. 30 days before a scheduled visit to a facility, he would meet with the directors for their input. He would at that time send a facility notification out to the air traffic manager and he may, or may not, have sent them the ECV checklist.

They were trying to combine facility ECV trips by lining up ECVs for two facilities within the same geographical location; they were trying to maximize their budget. They do not have the staffing for more ECVs than they are currently scheduling.

Mr. Ramirez was not aware of the FLM issues at SCT, the lack of refresher training for FLMs, the lack of IPM, or the level of experience of the FLMs. He felt it would be a challenge for FLMs to perform IPM on controllers without a sound knowledge base.

Mr. Ramirez said he had no authority over SCT regarding QC matters other than to report up to the directors. The directors would listen and provide guidance to what they wanted the QCG to do. They want us to fix problems, but we were limited as to what we were able to do.

There was a misnomer that there was not a good relationship between his QC department and the QA department. At the end of a day, when QA sent us work, the QC department got it done. There may have been some personality issues, but, the relationship was working. He did have one issue with an employee that resulted in a PRC and he continued to monitor it. He was getting information that there were some personality conflicts from QA and he was working it.

Getting ATSAP information was difficult depending on the event. ATSAP had privacy information attached to it. He would routinely be asked why he wanted the information, and what was his motive.

Mr. Ramirez believed IPM was lacking and it needed to be addressed. He would like to get out to more facilities but staffing and budget prohibited it. Lack of stability between the three service area QCGs was an issue and he would like to see more standardization. He used the operating guidelines signed September of 2015 by the three service area QCG group managers, but said it was in the process of being revised.

The FAA would defer any loss of separation, which generated an EOR and was validated by QA, if the MOC was 70% and above. He said there were no guidelines nationally that he was aware of to reopen the deferred folder of those EORs.

Interview concluded at 1000.

Interviewee: Brian Schimpf
Date / Time: January 13, 2017 / 1100
Location: FAA WSA
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Mr. Schimpf said the following:

Mr. Schimpf began working for the FAA as a direct hire reporting to the FAA training facility in November of 1982. He graduated in January of 1983 and reported to Seattle ARTCC (ZSE), Seattle, Washington. In May of 1985, he transferred to Seattle-Tacoma International Airport (SEA) ATCT, Seattle, Washington. In February of 1987, he transferred to Olympia Regional Airport (OLM) ATCT, Olympia, Washington. In February of 1988, Mr. Schimpf reported to Renton Municipal Airport (RNT) ATCT, Renton, Washington. In April of 1990, he transferred to Boeing Field/King County International Airport (BFI) ATCT, Seattle, Washington. In July of 1993, Mr. Schimpf returned to SEA and in January of 2007 left to work in WSA safety assurance. In January of 2009, Mr. Schimpf began serving as the senior advisor to the regional

administrator. He also served as the manager of the ROC for the WSA. In July of 2015, he became the WSA QA team manager.

Mr. Schimpf first became aware of the EVA015 incident on December 19, 2016 from the QA department at WSA. He was aware that there was no SRT conducted on Friday. He does not make the determination on whether an SRT is conducted. He felt the quality of the MOR was in line with what SCT always did, it was in house, and they were not going to “show their cards.” He felt SCT was part of a culture that was not part of transparency or reporting up, or working to identify trends. Some things would not get reported or if they did, they would be under emphasized. Mr. Schimpf felt that if QA did find something, SCT would deny it. He felt that SCT did not have a safety culture and in talking with SCT they were argumentative and not objective. He further described the safety culture at SCT as pathological. He felt that the difference between SCT and NCT was night and day, and that NCT had a great safety culture and in turn they had a great relationship between QA and NCT.

Mr. Schimpf said that he tried to reach out and find cooperation with SCT through Mr. Davis. He felt Mr. Davis was a nice guy, but it just was not within his skill set to be the ATM at SCT. He reached out to Mr. Davis, Mr. Karpe, and QC Manager Lori Penwell to help improve SCT. A change started to occur for the better, but then after a short period of time, SCT just went back to what was comfortable to them and not working with QA.

He advised that QA filed a lot of MORs for SCT because they did not report them and they did not file ATSAP reports. He felt under reporting was part of controller culture in the FAA but SCT was a lot worse than most places.

Mr. Schimpf said that QA did not offer solutions in their daily activities, they just validated, and that correcting deficiencies was QC and OSG’s responsibility.

Mr. Schimpf had made a bunch of suggestions to QC about how to interact better with each other, but QC had not embraced any of the suggestions. He felt for the QC department to say that the relationship between them and QA was not dysfunctional was “crazy.” He thought that QC was worried about their “model” and not disrupting the way they do things. He felt QC was not willing to be a partner in an initiative to make things better. He said that he was really bothered by management at upper levels in the WSA, that they do not want to be honest about what is going on and do not want to put effort into make it better. Mr. Schimpf felt that a lack of transparency was the main reason why the QA/QC process was not working. He would like to see the QA validator go to the facility with the QC specialist during ECVs.

Mr. Schimpf said they get hundreds of MORs and EORs per day, but they typically get things done within the time limits set forth in their operational guidelines. He felt the biggest challenge to this was CEDAR and Falcon not functioning properly and increasing the time it took to validate the MORs/EORs.

Interview concluded at 1300.

Interviewee: Michael Meigs

Date / Time: January 13, 2017 / 1400
Location: FAA WSA
Present: Mr. Jack Clark, Mr. Adam Rhodes
Investigator: Andy Olvis
Representative: Not represented

During the interview Mr. Meigs said the following:

Mr. Michael R. Meigs began with the FAA in September of 1987 and reported to the northwest mountain regional office as an engineer in the FAA NAVAIDs/COMMs²⁷ sections. In August of 2007, he transferred into the air traffic organization (ATO) runway safety office also in the northwest mountain region. In April of 2013, Mr. Meigs transferred to the WSA QA office as the group manager.

It was the WSA QA's job to validate all CEDAR EOR/MOR reports and make sure that the data was accurate and reflected what actually occurred in the field. Specifically, the QA office was responsible for determining losses of separation, pilot deviations, near midair collisions (NMAC), surface events, etc. They were the data stewards and had a responsibility to investigative parties like the flight standards district office (FSDO) to get them information. Additionally, they were supposed to identify risks through the risk process and trend tracker. They had an overall responsibility for compliance; though that was primarily a QC function, the QA specialist was the last line of defense. It was the QA specialist's job to hold a high standard and call out non-compliance when they detected it and make sure the director was advised.

The WSA QA office was comprised of 11 validators, one risk assessment program manager, one team manager, and one administrative person. Mr. Meigs said that the WSA QA office was short an analyst and was low on validators due to the sheer volume of MORs. NCT was the highest volume area because of the San Francisco airport (SFO) finals. SCT could be a challenge if one of the validators was gone and that they could get a week behind on MORs when that happened.

The QA validators used several tools in the conduct of their work; CEDAR and Falcon were two of them. The CEDAR and Falcon tools had issues and since they could fail from time to time it prevented the QA validators from getting work done on occasion.

There was not a 10-day requirement to complete the review of MORs and EORs. The QA SOP said, they were supposed to act on work assignments (MOR/EOR) within three days and complete the work within two days after all data was received. They did not generally meet the three day requirement on EORs, but on MORs the group was pretty good. The QA group was about to change the SOP and Mr. Meigs was not sure what the new one would say regarding the time restriction. They committed to the FSDO a 10-day requirement; they do pretty well with the 10 days.

²⁷ Navigational aids and communications.

Mr. Meigs said that SCT had problems with MORs being submitted. In 2015, SCT was at a point where there were 36 MORs that needed to be entered but had not. There were more MORs at SCT than any other facility in WSA. When SCT submitted pilot deviations, they often lacked details like pilot information, etc. NCT never had MORs like this and always had quality work. Mr. Meigs felt SCT was not holding the controller workforce to a high standard. The WSA QCG did not appreciate Brian Johnson's attention to detail or that he was holding the facilities he was responsible for to a high standard. Consequently, SCT was upset with Brian Johnson.

The WSA QA had a lot of trend data on SCT. When Brian Johnson or any of the other validators had enough information to identify a trend, they would bring Mr. Meigs the information and he would initiate a trend tracker. Depending on the trend, the QA would notify the QCG, or sometimes the individual facility. SCT was a little different; normally, the QA would run most communications through the QCG. That developed in late 2014 after there had been a national CAP for SCT. In 2015, the QCG spent one month down at SCT helping them with their QC program.

The relationship between QA and the QCG had two distinct levels. At the manager level, the relationship was good. Mr. Meigs felt they did not see the QCG enough. The QCG group manager was loaded down with meetings and it was only once a month for a couple hours the two groups would get together. At the specialist level, the relationship was all over the place. Mr. Meigs said that there could be a lot of conflicts between the QCG and QA specialists. Significant event reporting could be contentious between the two groups also.

Because of the contention between the groups, and the fact that some directors of operations were surprised about some of the events, the process was changed. Now, if a QA specialist observed what should be a significant event, they would now call the ROC and get the QCG specialist on the phone. The QA specialist advised the QCG and ROC that they were going to mark the MOR in CEDAR as significant. In some cases, this has resulted in an argument between the specialists.

In certain areas, SCT had gotten better with respect to reporting, but there were still significant issues that needed to be addressed. For example, not maintaining three miles and 1,000 feet until the aircraft was turned onto final approach. Other areas of required reporting still needed a lot of work. The WSA QA detected 30 events where lack of positive control existed. The QA worked through the QCG and told the facility about those events. The facility agreed with the MORs and generated a CAP. They then closed the CAP but the QA was still observing the same issues. Mr. Meigs was concerned the CAP should not have been closed.

The QC part of the QA/QC process was still not working as well as it needed to be. There were several areas that Mr. Meigs felt were contributing to the failure. The roll out of the QA/QC program was poorly executed with a lack of training and documentation. In some cases, it was the standard in which the facility held themselves to; a lack of accountability. Another issue that Mr. Meigs felt was contributing to the failure of the process was IPM. IPM was an ongoing issue and was not being accomplished by FLMs at the facilities.

According to Mr. Meigs, compliance did not seem important to SCT. SCT was the one place that in order to get compliance fixed, it had to go all the way up to the director. There was concern that the WSA QA had been hard on SCT. Mr. Meigs believed they were not hard on SCT compared to other facilities. It was the QAs concern that SCT had a history of non-compliance. Mr. Meigs was concerned with what type of culture was created by this type of behavior; that non-compliance was okay. During a meeting attended at the WSA, one team manager from QCG was heard telling SCT management that “we’ve got your back.”

Mr. Meigs believed that the WSA needed to get QCGs and the district in the same mindset with Tim Arel. That if the QA found non-compliance in the system, the WSA could put it on the table, acknowledge it, and talk about how to fix it. The ATO cannot just accept that non-compliance was just too hard to fix, or that a facility had done it this way all the time. Leaving non-compliant items as “acceptable” just leads to more problems. The QCG, QA, runway safety, and management reps from ERC, get together once a month and talk about what safety issues they see from their various programs. One of the main purposes of this group was to brief the district.

Interview concluded at 1600.