



NATIONAL TRANSPORTATION SAFETY BOARD

Office of Aviation Safety
Washington, D.C. 20594

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Group Chairman's Factual Report

AIR TRAFFIC CONTROL

CEN15FA316

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A. ACCIDENT

Location: Colbert, Oklahoma
Date: July 26, 2015
Time: 1508 central daylight time (CDT)¹ / 2008 coordinated universal time (UTC)²
Airplanes: N252G, Beechcraft V35B Bonanza

B. AIR TRAFFIC CONTROL GROUP

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C. SUMMARY

On July 26, 2015, about 1500 central daylight time, a Beechcraft V35B airplane, N252G, sustained substantial damage following loss of engine power in flight and subsequent impact with the ground in Colbert, Oklahoma. The instrument rated private pilot was fatally injured and the passenger was seriously injured. The airplane was registered to Avprop, LLC and operated by a private individual under the provisions of 14 Code of Federal Regulations Part 91 as a personal flight. Visual meteorological conditions prevailed and an instrument flight plan had been filed. The flight originated at Jackson County-Reynolds Field (JXN), Jackson, Michigan.

D. DETAILS OF THE INVESTIGATION

The air traffic control group convened at Fort Worth Air Route Traffic Control Center (ZFW ARTCC) on Monday, November 2, 2015. The group met with Tommy Graham, ZFW air traffic manager (ATM) for an inbrief. Others present were Kevin Davis, Nick Daniels, ZFW National Air Traffic Controllers Association (NATCA) facility representative, Travis Fiebelkorn, event investigation manager, and Jeff Hitchings, Central Service Area (CSA) quality control group (QCG). The ATC workgroup was given a tour of the ZFW Bonham specialty (BYP), reviewed all data related to the accident, and reviewed the training folders for the controllers to be interviewed. The workgroup interviewed the controller that was working the radar positions during the accident and the controller in charge (CIC) that was responsible for the watch.

¹ All times are expressed in central daylight time (CDT) unless otherwise noted.

² UTC – coordinated universal time – an international time standard using four digits of a 24-hour clock in hours and minutes based on the time in Greenwich, England.

On Tuesday, November 3, 2015, the group reconvened at ZFW and conducted interviews with the front line manager (FLM) of the watch who was getting currency time on position, the radar associate controller, and the operations manager. The group requested additional data in support of the investigation.

On Wednesday, November 4, 2015, the workgroup reconvened at ZFW and conducted an interview with the oncoming sector 37 controller who was assisting during the emergency. The workgroup then moved to the Central Service Area (CSA) where the group received an inbrief from Mr. Anthony Schneider, the QCG manager and his staff, collected data, and conducted interviews.

On Thursday, November 5, 2015, the workgroup reconvened at the CSA and conducted interviews with Henry Nagy, QCG specialist, Mark Clayton, QCG specialist, Brian Barker, ZFW on the job training instructor (OJTI), and Anthony Milligan, ZFW quality control manager.

E. FACTUAL INFORMATION

1.0 History of Flight

At 1501:42, the pilot of N252G attempted to contact ZFW. Eight seconds later there was a second attempt to contact ZFW.

At 1501:56, the ZFW air traffic controller acknowledged the pilot and told the pilot to go ahead. The pilot of N252G declared an emergency.

At 1502:04, the pilot transmitted “ah we’ve lost engine power, and we need ah to get to an airport right away.”

At 1502:10, the ZFW air traffic controller advised the pilot that the North Texas Regional Airport (GYI) was at the pilot’s 12 o’clock and about 15 miles. The pilot responded that he had partial power and that he would see if he could make it to GYI.

At 1502:22, the pilot requested vectors to the airport. The ZFW air traffic controller issued a vector of 245° to the airport. The air traffic controller also provided a traffic call for a visual flight rules (VFR) aircraft operating in the vicinity. A short time later the ZFW air traffic controller advised the pilot of the runway configuration at GYI, and the pilot acknowledged.

At 1504:17, the pilot asked for “something closer,” and the air traffic controller advised the pilot that the Durant Airport (DUA) was three to 4 o’clock and 10 miles. The pilot asked if it was a left turn towards Durant. The controller corrected him saying it was a right turn to DUA, and reiterated the location of the airport. The pilot asked for and was provided the location identifier for DUA.

At 1505:31, the ZFW air traffic controller advised the pilot “they’re showing a private field about 1 mile behind you called Cross Winds.” The pilot responded “wish I knew where that was for 52G.”

At 1506:10, the ZFW air traffic controller provided the runway configuration for DUA. There was no response from the pilot. Short time later the ZFW air traffic controller provided the pilot with the minimum instrument flight rules altitude (MIA) of 2700 feet for the area. The pilot responded “where’s that private strip for 52G?” The air traffic controller asked the pilot to say again, and the pilot once again asked about the private airstrip.

At 1507:06, the ZFW air traffic controller transmitted “it’s not close enough for you to get to, ah, there is GYI at your 2 to 3 o’clock 10 miles, Durant is at your 6 to 7 o’clock and 10 miles.”

At 1508:20, the ZFW air traffic controller made the first of several attempts to contact the pilot of N252G; there was no response from the pilot.

2.0 Radar Data

Radar data for this report was obtained from ZFW. Figure 1 illustrates the radar data superimposed on a map with GYI, DUA, and XWinds (Crosswinds Airport) identified. When the air traffic controller issued the pilot a vector of 245 degrees to GYI, the aircraft was 15.8 nm from the airport. It was only 7.5 nm south of DUA. About 3.6 nm later, the pilot requested a closer airport and the air traffic controller advised the pilot of the location of DUA.

Figure 2 is a picture from the Enroute Automation Modernization (ERAM) radar display showing the location of N252G shortly after the pilot declared an emergency, and before the controller issued the 245° vector to GYI.

Figure 3 is a picture from the ERAM display showing the location of N252G after receiving the 245° vector to GYI.

Figure 4 is a picture of the ERAM display showing the location of N252G after the pilot asked for a closer airport.

Figure 5 is a picture of the ERAM display showing the location of N252G after the ZFW air traffic controller had told the pilot that the XWind airport was 1 mile behind him.

Figure 6 is a picture of the track data overlaid onto a commercially available map showing the final segment of the accident flight.

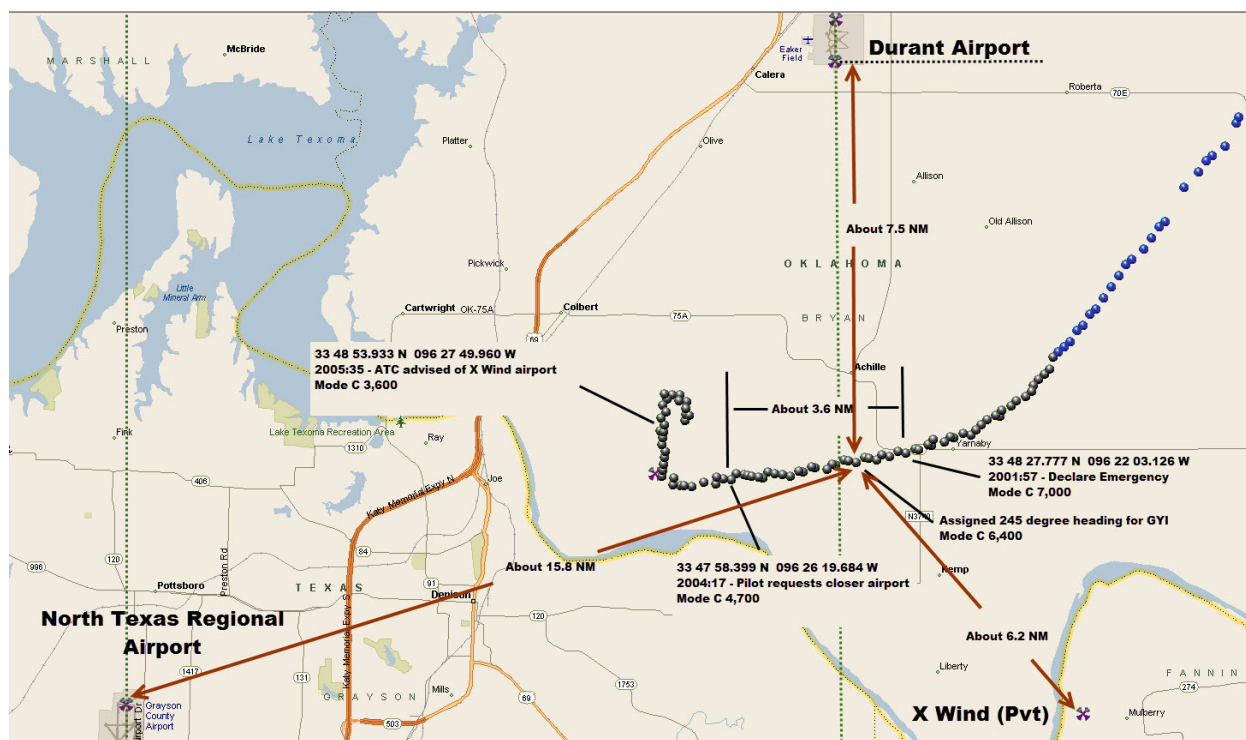


Figure 1 - N252G as the pilot was turned onto the final approach course.



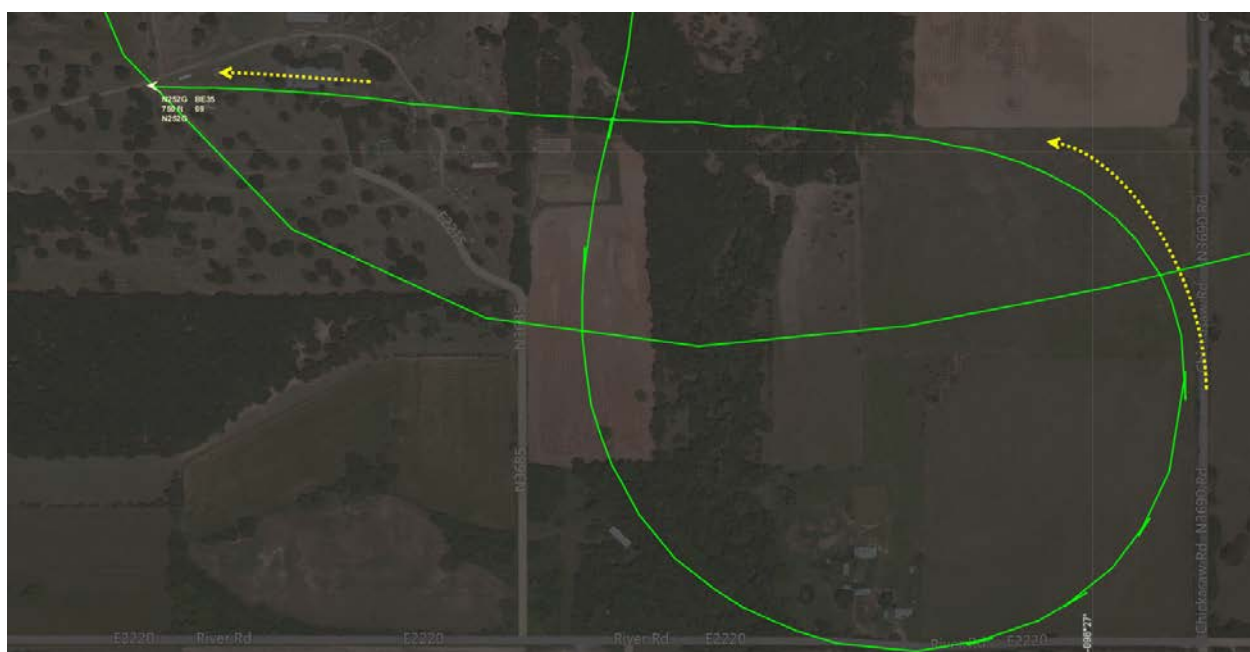
Figure 2 – Position of N252G at 1502:14 after declaring emergency but before being issued vectors.



Figure 3 - The radar position of N252G at 1502:29 after receiving a vector to GYI.



Figure 4 - The radar position of N252G at 1504:18 after pilot requested a closer airport; the aircraft is indicated by the "VFR/47" data tag.



3.0 Weather Information

The DUA airport weather was obtained from the DUA Automated Weather Observation System (AWOS). The 1935 UTC observation was:

KDUA 261935Z AUTO 19007KT 10SM CLR 36/19 A2993 RMK AO2

KDUA weather at 1935 UTC, wind 190 degrees at 07 knots, visibility 10 statute miles, sky clear, temperature 36° celsius (C), dew point temperature 19° C, altimeter setting 29.93 inHg.

4.0 FAA Services Review

4.1 Background

FAA order 1030.3A, *Initial Event Response*, contains FAA procedures to report and internally review ATC services provided to an aircraft involved in an accident or ATC event. FAA orders 7210.632, “Air Traffic Organization Occurrence Reporting,” 7210.633, “Air Traffic Organization Quality Assurance Program,” 7210.634, “Air Traffic Organization (ATO) Quality Control,” and 7200.20, “Voluntary Safety Reporting Programs (VSRP),” provide guidance to assist FAA facility and service area personnel in reviewing accidents and significant events in order to identify any risk in the ATC system. The FAA’s stated goal with these orders and procedures was to place value on, “...discovering why adverse safety events happen and in identifying risks, rather than determining who was at fault.”

4.2 Services Rendered Telephone Conference (SRT)

In accordance with FAA order 1030.3A, *after* a significant or noteworthy event like an aircraft accident, a services rendered telcon (SRT) should be conducted within 3 hours of the facility becoming aware of the event. During the SRT, the ATC facility reviews the services provided by the facility to the accident aircraft, and provides a synopsis of the event to FAA leadership. At the conclusion of the SRT, the Event Response Group (ERG) will determine a color code (red, yellow, or green), and the service area director of operations will determine the appropriate level of response.

The ERG classified the accident involving N252G as “yellow,” and the Central Service Area (CSA) Director of Operations set the level of response as “CSA Quality Control Group (QCG) follow up.” According to order 1030.3A, if an ERG team is not launched to investigate a “yellow” event, the service area director of operations is “...responsible for taking appropriate follow-up action, including the completion of an investigative report, as well as the upward reporting to ATO safety and all affected service unit vice presidents.” The NTSB investigated the QCG follow up that was required by the SRT determination, and could not find any “appropriate response” that had been initiated or completed by the CSA. Additionally, interviews with CSA QCG personnel revealed they did not know what their roles or responsibilities were for a “follow up” to an accident or event classified as yellow with CSA QCG follow up.

5.0 Personnel Interviews

5.1 ZFW Seaver Low (37)/DECOD High (42) Developmental Controller

Ms. Kari Legge began working for the FAA in October 2012 reporting to the FAA training facility for basic air traffic control. After graduating in January 2013, she reported to ZFW for duty. Ms. Legge was qualified on the McAllister High and Low sectors, KLUBB Ultra High sector, Frisco Low sector, Ardmore High sector, Choctaw Ultra High sector, DECOD High sector, and the Hugo Ultra High sector. She held no other aeronautical ratings and her medical certificate was current with no restrictions. Her immediate supervisor was Mr. Kobi Mitchell.

On Sunday, July 26, 2015, Ms. Legge worked her regular scheduled shift of 1315 to 2315, and was assigned to train on the Seaver Low sector, DECOD High, and Hugo Ultra High sectors combined; they were her last radar positions to train on in the specialty. Ms. Legge was being trained by Mr. Brian Barker. She had been training on the position for about two weeks. Mr. Barker was her secondary trainer and had been responsible for most of her training on the radar positions; more so than her primary instructor. Ms. Legge felt comfortable training on the combined positions, especially since they were her last three sectors and she had already qualified on the data positions or “D” sides for each of these sectors. She had been on the position for almost 2 hours when the accident occurred.

Ms. Legge had been working all the sectors combined at the DECOD High operating position. The CIC decided to de-combine the sectors, and Ms. Legge and her instructor were waiting to do so when N252G declared an emergency. She remembered the pilot had tried to call several times but had continuously been stepped on by the high sector frequencies. The pilot had declared an emergency with partial power and wanted the closest airport. Ms. Legge told the pilot of N252G about GYI, described the position as 12 o'clock and 15 miles, and provided the pilot with the runway information. During the emergency, they were preparing for an arrival push and those aircraft had been checking in on frequency. She told the CIC about the emergency, and when Chris Martin returned from a break, the CIC instructed him to open the radar associate position to assist Ms. Legge. Mr. Martin began accepting handoffs from adjacent facilities and sectors, but asked them to delay switching the aircraft to their frequency in order to allow Ms. Legge time to sort out the emergency.

A short time later, the pilot advised Ms. Legge that he could not make GYI, and asked for a closer airport. She issued the pilot the position of DUA, and provided the runway configuration. She remembered Gordon Jones and the CIC were looking at a VFR sectional on the overhead panel trying to find an airport suitable for the pilot. Mr. Jones had been standing on the console to see the VFR sectional map.

Mr. Jones had been waiting to split the sector when the emergency occurred, and stayed around to observe and assist Ms. Legge. Either Mr. Jones or the CIC had told her about XWinds Airport, a private airport near the emergency aircraft. She told the pilot that the XWinds Airport was 1 mile behind the aircraft, but she kept asking the CIC and Mr. Jones where the XWinds Airport was located. She could not remember who, but someone then told her that the XWinds Airport was actually 10 miles from the aircraft and too far away to reach. Ms. Legge told the pilot the XWinds Airport was too far away, and reiterated the location of DUA. The aircraft was making a

descending right hand turn when she lost radar contact. Ms. Legge tried to locate the aircraft on radar and on the sector frequency, and informed the CIC when she could not contact the pilot.

Ms. Legge continued working the position after the accident aircraft had been lost from radar. She had not done anything with the arrival push and felt it was above her ability level, so she asked her trainer to work out the traffic. She was then relieved from the position. Ms. Legge watched the arrival push, and was not aware of the CIC's activities looking for the accident aircraft.

Nobody from the facility had said anything to Ms. Legge about the accident until she returned from a break. She spoke to the NATCA representative, Mr. Eric Johnson, who told her she could not work on position until the covered event review³ (CER) was complete. She did not resume work for about 8 days. During the CER process, she had spoken with Mr. Milligan about the event. He had not said anything to her about her performance or the performance of the team while working the emergency. She was not aware that she had not issued the accident aircraft the altimeter when he had checked on the sector frequency.

Ms. Legge had provided the GYI runway information to the pilot because it was straight ahead of the accident aircraft. She was not aware of the aircraft's limitations when the pilot said he had partial power, and believed that with a loss or reduction of engine power, any significant turn issued would result in altitude loss. Ms. Legge was not certain why she did not offer DUA to the pilot, and said that the trainer had not suggested DUA either. Ms. Legge had not pulled up the XWinds Airport information on the En Route Information Display System⁴ (ERIDS) indicator.

The DECOD sector was the busiest sector during the Dallas Ft. Worth International Airport (DFW) arrival push. When there were no sequencing activities to DFW, the sector was manageable combined.

Ms. Legge had never had a performance record of conference (PRC)⁵ discussion with her supervisor and was not completely familiar with what they were. As a result of the accident, Ms. Legge requested leave while waiting for the facility to complete the CER. While on leave, Ms. Legge was advised that the regional flight surgeon had taken away her medical certificate while awaiting a brief of the event. The new NATCA facility representative assisted Ms. Legge in getting the required paperwork back to the flight surgeon. Ms. Legge returned to work the next Tuesday.

³ A CER supplements and documents the existing required review of air traffic services rendered during an aircraft accident. In addition, CERs require air traffic control facilities to review each accident in-depth, looking beyond the areas of individual performance. A CER must include a review of all aspects of service (individual performance, equipment issues, weather, etc.) and identify any issues that cannot be ruled out as potentially contributing to the accident.

⁴ According to the FAA, ERIDS provides controllers, supervisors, and traffic management personnel with access to aeronautical data, weather data, airspace charts, ATC procedures, notices to airmen, pilot reports, and other sources of ATC information.

⁵ According to the FAA, performance management is based on the day-to-day interaction between employees and their direct supervisor. This interaction permits the supervisor to assess an employee's performance relative to the outcomes and expectations in the employee's performance plan. Periodic discussions with employees regarding performance can be documented in CEDAR as a Performance Record of Conference.

Ms. Legge said the dynamic simulation (DYSIM)⁶ training on the radar system had improved, but the computer based training modules were lacking.

5.2 ZFW Bonham Specialty CIC

Mr. Michael Okray began working for the FAA in September 2003 at ZFW as a direct hire with the FAA veterans readjustment act (VRA) program. He attended the FAA training facility for basic air traffic control in December 2003. After graduating in February 2004, Mr. Okray reported back to ZFW. He was qualified on all positions in the BYP specialty. Mr. Okray's prior ATC experience was as an air traffic controller with the United States Marine Corps. He held no other FAA ratings and his Class II medical certificate was current with no restrictions. Mr. Okray had been a CIC since 2010.

On Sunday, July 26, Mr. Okray was scheduled to work from 1330-2130. After reporting for duty, he was assigned the CIC position for the BYP specialty. Mr. Okray believed the day shift supervisor was at a weekly team briefing, and the FLM for the evening shift was getting currency on a position in the specialty.

Mr. Okray first learned about the emergency with N252G from the training team at the DECOD High, Seaver low, and KLUBB ultra-high combined sector. The sector team informed him the pilot had declared an emergency due to an engine failure. Mr. Okray called the front desk operations manager to advise them of the emergency in progress, and walked over to the position to monitor the situation. He briefed an available controller about the emergency and assigned him to the sector's radar associate position to assist. Mr. Okray asked that the sector team keep him updated and informed of the situation.

Mr. Okray had overheard a discussion about using either the DUA or GYI airport for the emergency, but had not been involved in that decision making process. He also said that he was not involved in determining the position of the private XWinds Airport relative to the position of N252G. He remembered Gordon Jones had been standing by to split off the Seaver low sector from the training team, but that the OJTI had delayed de-combining because it would further complicate matters. He did not remember anyone inquiring about the number of persons on board the aircraft, fuel, or any other information about N252G.

Mr. Okray had called the OM two or three times to notify him of the situation, but he could not remember if the OM was present in the specialty for any period of time during the emergency. The OM did visit the specialty after the accident had been confirmed.

Once the sector had lost radar and radio communications, Mr. Okray obtained the last known latitude and longitude coordinates for N252G from the controller sitting at the Frisco low sector and notified the OM of the position. He correlated the data and determined what towns or cities to call in order to obtain assistance from law enforcement. When Mr. Okray called the second law enforcement agency, they told him that the aircraft wreckage had been located; he could not remember which agency that was. He remained as the CIC for some time after the accident but

⁶ DYSIM is a simulation system used to simulate air traffic on radar displays so that air traffic controllers can practice.

could not remember for how long. The FLM for the evening shift was getting currency on a different position within the specialty, and was aware of the emergency. Mr. Okray could not remember how long afterward the FLM remained on position.

Before the emergency, the sector had not been busy or complex. The volume increased because of the “rebank” or arrival push, and the emergency increased the complexity. After the accident, the sector returned to routine, steady traffic. Mr. Okray said that he had a plan and people to de-combine the sector Ms. Legge was working, but the emergency prevented or delayed this plan. He could not remember the precise monitor alert parameter (MAP)⁷ numbers for the sectors that handled the emergency, but did not believe the sector exceeded the MAP. There was no very specific time for an increased volume or arrival pushes. There had been a plan in place, and there was no need to de-combine the sector any sooner. It was normal to combine and de-combine the Seaver and DECOD sectors throughout the day. Mr. Okray was not aware of any requirement to call the OM and report a mitigation strategy for sectors that are expected to experience demand exceeding the MAP number.

Mr. Okray said he worked with the OJTI and considered their input along with traffic loads and complexity when considering whether to allow a developmental controller to work sectors combined. He said the trainee and her OJTI had mutually agreed that the instructor would take over working the traffic once the sequence and spacing started to get behind. Mr. Okray believed that when the aircraft declared an emergency, it was directly before the sector was to be de-combined. His plan to de-combine had been developed about 20 minutes before N252G had declared an emergency.

Mr. Okray described good teamwork in the specialty and that he did not believe the controllers had done anything wrong. He had a highly qualified team in place and trusted them to handle the situation appropriately. He wished he knew that the OM had the necessary emergency response phone numbers readily available at the OM desk. He would like for information such as phone numbers to be more readily available to CICs, and described the watch desk as having clutter on it; it was tough to find information quickly. He had not been logged into the FLM workstation computer because of a personal identity verification issue.

When ZFW conducted the CER, Mr. Okray said that he was questioned and was provided feedback on the controller handling of the accident aircraft by the QC department. He described the CER as a way for the facility to learn from the event. He did not feel the CER was an interrogation, and explained that the CER panel questioned the configuration status of the sectors at the time of the accident. There was no additional after-accident guidance given on staffing or resource management.

Mr. Okray could not remember the last time he received any CIC refresher training. He said the CIC course and his experience was what helped him to manage the specialty effectively. He could not remember any training on staffing issues or resource management since being

⁷ The Monitor Alert Parameter (MAP) establishes a numerical trigger value to provide notification to facility personnel, through the MA function of the TFMS, that sector/airport efficiency may be degraded during specific periods of time.

designated a CIC. Mr. Okay described training as a lot of superfluous computer based instruction modules. However, the modules with air traffic control content were good.

5.3 ZFW Bonham Specialty FLM

Mr. Kobi Mitchell began working for the FAA in December 1999 and reported to the Jackson, MS (JAN) Airport Traffic Control Tower (ATCT) for duty as an air traffic controller. After reporting to JAN for duty, he attended the FAA training facility for training and returned to JAN. Mr. Mitchell transferred to ZFW in September 2001 and was assigned to the Cedar Creek Specialty (CQY). He was qualified on all of the CQY sectors and worked there for 13 years before accepting a position as an FLM in the BYP specialty in September 2014. Mr. Mitchell was certified on the McAlester (MLC-H) High Radar and KLUBB (KLB) Ultrahigh Radar positions in BYP. Before joining the FAA, Mr. Mitchell was employed at the Department of Defense from January 1996 to December 1999 at Key Field Airport, Meridian, Mississippi (MEI). He also worked at various Mississippi Air National Guard installations for 20 years before retiring. He held no other aeronautical ratings and his medical certificate was current with no restrictions. His immediate supervisor was Mr. Kevin Lagaly.

On Sunday, July 26, 2015, Mr. Mitchell worked a 1430 to 2230 shift to cover for a peer FLM in lieu of his regular scheduled shift of 0630 to 1430. He arrived at work early at 1330 and completed various administrative tasks before entering the BYP specialty at 1400. Mr. Mitchell checked to see if the CIC, Michael Okay, needed anything before taking the MLC-H position at approximately 1405 for currency time. He had been on position for almost 1 hour when the accident involving N252G occurred. He became aware of the emergency when he heard commotion at Ms. Legge's position, and observed the CIC, Bryan Barker, Christopher Martin, and Gordon Jones offering advice.

Mr. Mitchell became busy working aircraft in his airspace and assumed the emergency aircraft had landed safely. He learned N252G was involved in an accident when he was relieved from position at 1622 but could not remember how he was notified. There were no distractions in the specialty or equipment outages during the event that Mr. Mitchell could remember.

Mr. Mitchell reviewed a replay of the event with the operations manager for the shift and listened to the audio recording. He described the accident as tragic and did not remember having any impression about Ms. Legge's decision to vector N252G to GYI when the emergency began. Mr. Mitchell said that it was probably easier for the aircraft not to make any hard turns towards DUA, but was unsure if any turn would be required if the pilot had managed to make GYI. Mr. Mitchell had been trained on aircraft in emergency situations via CBI and DYSIMs, but felt that real life experience was the most effective training scenario.

The SEA-L/DECOD-H sectors were normally split for the American Airlines arrival "pushes" at 0630, 0830, 1530, and 2030. Mr. Mitchell was advised by the CIC of a plan to split the sectors when he first arrived in the specialty, but did not know the specifics. The normal MAP for the sector to alert "red" for the number of aircraft in the combined position was 18. He said there was a requirement for the FLM/CIC and the traffic management unit (TMU) to develop a plan for addressing a sector that was going to exceed the MAP number, and subsequently advise the operations manager and controllers of the plan. This requirement was part of a corrective action

plan (CAP) related to a previous fatal accident and national TMU requirements. Normally, once SEA-L/DECOD were split it would remain that way until preparing for the mid-shift. The traffic on weekends was described by Mr. Mitchell as 20% lower than during weekdays. Mr. Mitchell said that it normally took about 3 to 5 minutes to split sectors once a decision was made to do so. He said that he was not surprised to see a developmental working a combined position on a weekend shift.

Mr. Mitchell participated in the CER for the event as a witness and answered questions from Anthony Milligan and Pamela Shedden (Local Safety Council) regarding the accident. The questions were related to staffing, and sectorization. The decision to clear N252G to GYI instead of DUA was not discussed in the CER. He did receive some performance feedback from Kevin Davis, Kevin Lagaly, and Phillip Harris on lessons learned, including splitting the sector earlier and OJTI intervention.

Mr. Mitchell said he had 3 CICs on his crew, and if there was something pressing with traffic loads or staffing he would give them specific staffing instructions and notify the OMIC that a CIC was supervising the specialty. He said that CIC refresher training was done annually, although he did not remember conducting CIC refresher training this year. He said that there was no FLM peer-to-peer briefing on what training for employees was due but there was a ZFW webpage showing the requirements that he checked daily. Mr. Mitchell had a performance discussion with Ms. Legge regarding this event, but did not document the discussion because she was a developmental. He also had not documented performance discussions with employees due to time constraints and contractual obligations related to the bargaining unit.

5.4 ZFW Seaver Low (Sector 37)/DECOD High (Sector 42) Radar Associate

Mr. Christopher Martin Sr. began working for the FAA as a direct hire in June 1991. He graduated from the FAA training facility in October 1991 and had been at ZFW since then. He was certified in several of the operational specialties, and was current and worked in the BYP specialty; he was also designated a CIC and OJTI. His Class II medical was current with a restriction for vision and corrective lenses, which he had on him the date of the accident. Mr. Martin held no other aeronautical ratings. Rusty Ogden was his supervisor when the accident occurred, but his current supervisor was Rick Brown.

On July 26, Mr. Martin was scheduled to work a 1500 to 2300 shift. After he returned to the BYP specialty from a break, he heard Brian Barker say that a pilot had declared an emergency. Mr. Martin said the sector was not busy, but he sat down on the radar associate position to help as needed. The radar controller advised the accident pilot of the position of GYI as Mr. Martin plugged into the sector. He noticed there was a controller on the R37 radar position, but realized that the sector was still combined at DECOD high. The FLM was in the specialty getting proficiency time on an adjacent sector. Mike Okray was the CIC, and all other positions were open with moderate or less traffic. He remembered the accident aircraft asking for a closer airport and that the controller advised the pilot of the position of DUA.

Gordon Jones was scanning a VFR sectional chart and advised the controller about a private field called XWind airport. Mr. Martin said that the radar controller told the pilot the private airport may be behind the aircraft. He did not remember a distance to the private airport or who had

estimated that information. Mr. Martin called the Memphis Air Route Traffic Control Center (ZME) sectors and TXK High sector to accept radar handoffs on aircraft, but advised them to delay the frequency changes as there was an emergency in progress. He said that radar contact was lost on the emergency aircraft shortly thereafter. Mr. Martin remembered the minimum information required to handle the emergency had been obtained from the pilot, but did not remember any discussion about POB, fuel on board, or any other additional information about the emergency.

Radar coverage was limited farther away from DFW, and generally got better closer to the metroplex. After the accident, the sector was dealing with an increased volume of traffic to the metroplex. The loss of radio communications and radar contact with N252G was reported to the CIC immediately and Mr. Martin had no further dealings with the emergency. He had never been to the XWind airport and remembered perhaps three airplanes had landed there in five years. Mr. Martin believed that Ms. Legge's initial response and heading towards GYI was reasonable as the airport was directly in front of the aircraft. He was trained to advise the pilot of the closest airport.

Mr. Martin had received emergency training as an air traffic controller, but it had been general in nature. He said the controller reaction to simulation training would be mixed, somewhat like a CBI. He would prefer simulation that was unique to emergencies and provided teachable moments; something less predictable.

Mr. Martin had received CIC refresher training, but could not remember by whom or when. That training included how to access information in the Traffic Situation Display (TSD)⁸, ERIDS, CRU-ART⁹, accessing phone numbers, and training sheets. Mr. Martin said the arrival push was usually between 15:15 and 15:30, but that was not always the case. Sectors were combined or de-combined based on traffic, workload, and/or staffing. Mr. Martin was not aware of how the training team had determined the distance to XWinds airport, but soon after telling the pilot about it, the radar controller training team realized the private field was further away than initially stated. Mr. Martin said it was not too difficult to correlate a target's position on the radar display with a private airport on the VFR chart at Seaver low; however, doing so from the radar associate position would be more difficult.

Mr. Martin was not aware if the FLM or OM had issued an Alert Notice (ALNOT)¹⁰. He did not participate in the CER. His recommendation was to add more airports/features such as roads to the emergency airport key. According to Mr. Martin, the competency of the team was more than adequate. They did the best they could given the situation, and he was proud of the teamwork. He described the digitized VFR sectional in ERIDS as cumbersome to use. The newer, larger screen for ERIDS functioned better than the old display system, but the search functionality prevented information from being readily available.

⁸ A tool used by traffic management specialists to monitor the position of air traffic and to determine the traffic demand on airports and sectors.

⁹ CRU-ART is used to manage schedules, time and attendance (T&A) data and Labor Distribution Reporting (LDR) information.

¹⁰ A request originated by a flight service station (FSS) or an air route traffic control center (ARTCC) for an extensive communication search for overdue, unreported, or missing aircraft.

In the past, Mr. Martin had logged into the FLM computer when he was the CIC. He was familiar with the requirement to call the OM when a sector MAP was exceeded in order to relay mitigation efforts. He said that years ago he was trained that when an aircraft informed ATC of an engine issue or loss of power, the first response by ATC was to ask the pilot if the aircraft could maintain altitude. This dictated the rest of the emergency response and decision making process.

Mr. Martin described the scale of the display when combined to be 95-100 miles, and noted that that determining the difference between two or three miles was somewhat challenging to new controllers.

5.5 ZFW Oncoming Seaver Low (Sector 37) Controller

Mr. Gordon Jones (GS) began working for the FAA in April 1989. He graduated the FAA training facility in July 1989, and reported to ZFW ARTCC where he has remained. He has certified on several sectors, and was currently certified and actively performing ATC duties in the BYP specialty. His Class II medical was current with a restriction for vision and contacts. He held a commercial pilot certificate with instrument and flight instructor ratings, but was not current. His current supervisor was Rick Brown. Mr. Jones said he has had three or four supervisors in the last year.

On July 26, Mr. Jones was scheduled to work from 1500-2300. After he reported for duty in the specialty at about 1457, the CIC asked him to de-combine Seaver low from DECOD High. He explained it normally took three to five minutes to de-combine the position. Mr. Jones was surprised that the sectors were combined and explained that by that time on Sunday the sectors were always split. Traffic dictated that Seaver and DECOD be split much earlier in the day shift.

Mr. Jones began setting up the sector, entering codes, invoking his user settings, and setting up ERIDS and the User Request and Evaluation Tool (URET)¹¹. Once this was complete, he attempted to split the positions, but the radar controller training team at DECOD said they were too busy. Mr. Jones waited and watched the training team's sector to monitor and observe. The pilot of N252G called a couple of times without ATC response, but was finally able to report to ATC that he was experiencing a loss of power. Mr. Gordon realized the pilot needed an airport, and understood the pilot could not maintain altitude. He began to search the VFR sectional since he was concerned the pilot could not make GYI or DUA. He stood up on the console and used his reading glasses to search for a suitable place for the pilot to land. Mr. Jones said it was very difficult to correlate an aircraft target symbol on the radar display with the VFR sectional chart; the differences in their respective scales made it challenging. Having an optional map on the radar display with major features such as rivers and highways would have been helpful to correlate the position of the aircraft with the airport.

Mr. Jones said that as a pilot experiencing an emergency, you should aviate, navigate, and communicate in that order. He did not remember considering DUA. He did not remember details about the XWIND airport, or who had relayed that information to the controllers, but he did

¹¹ URET is a tool to help air traffic controllers detect and resolve potential conflicts between aircraft and between aircraft and airspace.

remember a discussion about a private airport. If it was in range, he may have mentioned it as an option to Ms. Legge. He did not know who, or how, the one mile distance provided to the pilot was determined. Mr. Jones explained he would never attempt to inform the pilot of the location with that much precision. He said the training team may have misinterpreted some information that was being heard around them.

The CIC had a presence, but Mr. Jones did not remember where the CIC was at all times of the accident. He did not remember the pilot asking the controllers to help him navigate to XWind. Mr. Jones was not the person who said that XWind was too far away for N252G to reach.

Mr. Jones was wearing his headset at the console while this emergency was taking place. He estimated the emergency aircraft to be about five miles north of BYP when the emergency began.

Mr. Jones was not involved in the CER, had not been questioned about the event, and had not been provided any feedback regarding the emergency. Mr. Jones said that once Seaver and DECOD were de-combined, they almost always remained in that configuration until late evening for the mid-shift. Mr. Jones certified on Frisco Low two or three years ago, and was very familiar with GYI and DUA airport.

It made very little difference to a pilot experiencing an emergency condition if an airport had tower services; the most important thing was finding a runway. Mr. Jones said he would not normally see or expect a trainee to train on the sectors combined with such low experience at the sector.

In retrospect, Mr. Jones said he would have isolated the emergency aircraft from others so that exclusive service could have been provided to the pilot. Mr. Jones felt services were compromised because of Seaver and DECOD being combined. He was not involved with search and rescue coordination after the accident occurred.

5.6 ZFW Operations Manager in Charge

Mr. Phillip Harris began working for the FAA in May 1991 at the FAA training facility for basic air traffic control. He reported to Fort Worth (ZFW) Air Route Traffic Control Center (ARTCC) in September 1991 for air traffic control duty. He accepted a position as an FLM in August 2005, and became an OM in August 2015. He held no other aeronautical ratings and his medical certificate was current with no restrictions. His immediate supervisor was Mr. Kevin Davis.

On Sunday, July 26, 2015, Mr. Harris worked a 1430 to 2230 shift in lieu of his regular scheduled shift of 0630 to 1430. He arrived at work early at 1430 and received a position relief briefing for the operations manager position from the relieved OM, Mr. Cary Davis. The briefing from Mr. Davis did not include information regarding about any control positions exceeding their MAP values.

Mr. Harris was preparing an information sheet for the 1500 “stand-up” meeting with the evening shift FLMs when he was notified by the BYP specialty CIC of a VFR emergency aircraft. He went to observe the emergency from a radar display while also gathering information on the

aircraft. Mr. Harris received additional information that the aircraft was losing power and not going to make it to an airport. He began to prepare an ALNOT for the aircraft and communicate with emergency officials at DUA airport. He could not remember if the aircraft was closer to GYI or DUA airport; however it was his past technique to give an emergency aircraft information on all nearby airports and let the pilot decide which airport they could reach. The crashed aircraft was found a short time later, and Mr. Harris began working with a BYP specialty FLM, Mr. Kobi Mitchell, to prepare for a services rendered telcon (SRT) with members of the FAA air traffic organization (ATO) safety group.

Mr. Harris reviewed a replay of the event with the FLM and said that he was alarmed that the Seaver and DECOD positions were combined. He said that DECOD was one of the busiest positions in the facility and the training team working the positions was “very busy.” Mr. Harris relied on information from the FLM, Mr. Mitchell, to answer questions on the SRT, and incorrectly said on the telephone conference that this was “normal” to combine Seaver and DECOD.

As a result of the lessons learned from this accident, FLMs have been briefed to call the OMIC and inform them anytime a sector will exceed the MAP numbers, along with a plan to mitigate the traffic. This policy was not written, and was part of a previous ZFW CAP in response to a fatal accident involving resource management (staffing). ZFW has also changed the times of the stand-up briefing to allow an additional 30 minutes to prepare for crew briefing and avoid overlapping with shift changes. The CICs had not received this guidance as of yet.

Mr. Harris participated in the CER of the event and answered questions from Anthony Milligan and Pamela Shedden regarding the accident. The questions asked related to search and rescue, ALNOTs, and staffing, with no questions related to airports. He provided feedback to Mr. Mitchell regarding sectorization and combining positions to increase breaks, but did not give any feedback to the CIC. Mr. Harris said that he and the other ZFW OM are relying on the FLMs to give the information to the CICs.

5.7 ZFW Seaver Low (Sector 37)/DECOD High (Sector 42) OJTI

Mr. Brian Barker began working for the FAA in September 2000, assigned to Albuquerque Center (ZAB) until July 2004. In July 2004, he transferred to the Secret Service as an air security supervisor. In August 2005 he returned to ZAB. Mr. Barker transferred to ZFW ARTCC and worked in the BYP specialty until early October 2015, when he transferred to the ATC System Command Center. Mr. Barker was on active duty in the Air Force from June 1996 until June 2000, serving as an ATC officer. His class II medical certificate was valid with a restriction for corrective lenses. Mr. Barker said he was wearing them when the accident in question occurred. He holds no other FAA ratings.

On July 26, Mr. Barker was scheduled to work from 1315 to 2115. He did not flex in, and was not working overtime. Mr. Barker reported for duty in the BYP specialty, and the CIC told him that he would be training a developmental on DECOD high radar position. He could not remember if the sectors Seaver and DECOD were combined or not when they began the training session. He said that they began working the DECOD high sector, and could not remember

exactly when the sectors were combined up as Seaver and DECOD. The traffic load was described as light when they first began to train.

Mr. Barker was aware that it was Ms. Legge's second day training at DECOD high. He said traffic began to increase, but he was not concerned because he and the CIC had agreed on a plan to de-combine Seaver from DECOD. Mr. Barker said N252G declared an emergency due to an engine failure and partial power. Once the emergency was declared, he and Ms. Legge quickly discussed a plan for the aircraft to go straight ahead to GYI, about 12 miles away. DUA appeared to be about the same distance off the right side of the aircraft. Mr. Barker said that GYI was the best option because the airport had a control tower, emergency services, and the vector to GYI was easier on the pilot. DUA would have very limited, if any, services for the pilot. Mr. Barker said the runway configuration at GYI was north-south, and less than a 90 degree turn to final. He said it depended on many variables, but going straight and level was preferred. Mr. Barker did not remember where he received training to go straight ahead instead of directing pilots to a closer airport that needed a turn to reach.

Once the pilot said he needed a closer airport, Ms. Legge issued information for DUA. Mr. Barker was actively searching the VFR sectional overhead to identify any other suitable options, and Gordon Jones was helping him with the map. Mr. Barker said Mr. Jones suggested the XWind airport and estimated the field to be about 1 mile behind the aircraft in distress. Mr. Barker heard the pilot say that he wanted help finding the private field.

According to Mr. Barker, correlating a target on the radar display with a position on an overhead sectional chart was very difficult. He agreed that having some geographic features such as rivers, state lines, and major highways for a frame of reference on the radar display would have been helpful. He and Mr. Jones determined that the initial estimate was inaccurate, and the XWind airport was too far away for N252G to reach it. Therefore, DUA became the best option. At this point he said the traffic had increased, but he was uncomfortable de-combining the sector given the volume and emergency.

After they lost radio and radar contact with the aircraft, the training team notified the CIC. Mr. Barker stayed on DECOD high and suspended training. He was not aware that traffic volume had exceeded the normal MAP level of 18. The CIC and FLM might or might not advise controllers that a sector was exceeding the MAP parameter. Mr. Barker emphasized that there had been a plan to split the two sectors, but the emergency prevented the split. Mr. Barker said those two sectors are not typically combined at that time of day. Mr. Barker said he was not qualified as a CIC.

There had been a local safety investigation at the facility regarding the accident and Mr. Barker had been questioned about it. He said there had been feedback, but could not remember the substance. Mr. Barker said there was nothing more they could have done for the pilot, and he would not necessarily change anything they had done. Mr. Barker believed the MAP numbers changed when the sectors were combined versus when they were split. He said the annual emergency training and CBIs were effective. Mr. Barker said that having more specialized training into the aircraft capabilities and limitations under partial or no power could have been helpful.

5.8 ZFW QC Manager

Mr. Anthony Milligan joined the FAA in March 1987, reporting to the FAA training facility in Oklahoma City, OK. After graduating in July 1987, he reported to Santa Barbara, CA. In November 1992, he left and reported to Chicago TRACON (C90). In November 1997, he left C90 and reported to the FAA Command Center. In May 2000, Mr. Milligan left the Command Center and reported to SoCal TRACON. In May 2005, he left SoCal and reported to Chicago Center (ZAU). In October 2008, He reported to DFW TRACON (D10), and in June 2013 he reported to Ft. Worth Center (ZFW) for duty as the QC manager, where he has remained.

Mr. Milligan became aware of the aircraft accident involving N252G via the televised news. He called ZFW to speak with the OM and was told that “everything was under control.” On Monday, July 27, 2015, ZFW QC staff members arrived at the facility. They gathered audio recordings, created a Satori replay, and began making audio transcripts related to the accident. On his initial review of the accident, Mr. Milligan was concerned that the BYP Seaver and DECOD sectors were combined and the information provided to N252G did not meet his expectations. His opinion was the controller cleared N252G to one airport, then a second, before clearing the aircraft to a private strip without providing additional information.

Mr. Milligan conducted a CER with Pam Shedden as part of a collaborative review process. He characterized the CER process as “fact finding” to provide information to the ZFW management team and not for providing controller feedback. Interviews were scheduled initially with the FLM, CIC, OJTI, D-side, and later with the developmental air traffic controller. He described the CIC as “very articulate” describing his plan, which had not been executed well. The OJTI led Mr. Milligan to believe Ms. Legge was close to certification and Mr. Milligan was not aware of her inexperience on the Seaver and DECOD positions. During the CER discussion, the OM acknowledged he did not follow procedures from a previous CAP regarding facility resource management requirements. Mr. Milligan asked the controllers involved about the initial decision to clear N252G to GYI airport. Their opinion was that “you give them the closest airport straight in front of them.” He could not find that guidance as part of the ZFW training, and believed it may have been learned from previous facilities.

At the conclusion of the CER, Mr. Milligan met with the BYP specialty FLMs to watch a replay of the event and have a robust discussion about resource management. Mr. Milligan said only one of the BYP FLMs defended the staffing at the time of the accident, and had since resigned as an FLM.

When an FLM felt it necessary to counsel a controller following an event, the individual performance management process was expected to take place no later than 10 calendar days following the observed performance to ensure the quality of feedback. Mr. Milligan said the “10 day rule” was creating problems with addressing individual performance management, and was further exacerbated by the reduced number of FLMs at ZFW.

FAA order 7210.634 *Air Traffic Organization (ATO) Quality Control* required ZFW to conduct an internal review of their compliance with FAA policies, procedures, and directives. An internal compliance verification (ICV) conducted in 2014 found that the facility was not properly managing CIC training. The observation was categorized as non-compliant low-risk, and

required ZFW to have a plan to correct the deficiency before declaring the problem resolved. The ICV process required an item identified as non-compliant low to only have a plan in place to correct the item. The item can then be reclassified as “compliant” in the compliance verification tool regardless of the status of the plan implementation. Michael Turner, the ZFW training manager, was responsible for establishing the plan to complete CIC refresher training and the implementation of the plan.

Mr. Milligan said the SRT regarding this accident was “rushed” as a result of the requirement that it be conducted within 3 hours. The SRT was done 1 ½ hours after the accident, and there were too many ongoing activities to get a good product. Mr. Milligan suggested the FAA allow facilities to request additional time to prepare for an SRT related to a fatal accident.

5.9 Central Service Area (CSA) Quality Control Group Manager

Mr. Anthony Schneider began working for the FAA in August 1986 as an FAA COOP employee from Embry Riddle Aeronautical University, Daytona Beach, FL. He graduated from the FAA training facility in 1986 and reported to Jacksonville ARTCC (ZJX) for duty. In 1992, Mr. Schneider transferred to the FAA Aeronautical Center in Oklahoma City, OK, and in 2000 he transferred to ZFW. In 2009 he transferred to the Central Service Area, and became the QCG Group manager in 2012. His current supervisor was Gus Nezer.

Mr. Schneider described how the QCG became involved in the accident review. The QCG had an on call specialist who was notified by the Regional Operations Center (ROC) that N252G had crashed after the ROC had been notified by ZFW. The QCG on call specialist relayed the information to the FAA headquarters AJI on call specialist. The Director of Operations was responsible for determining whether to drug test the controller involved, AJI was responsible to color code the event, and the Director of Operations or the deputy would determine the follow up.

If an air traffic event was marked ‘yellow with QCG follow up,’ the QCG specialist working would be required to ensure either the CER or system service review (SSR) was completed and submitted. A fatal accident required that a CER be completed within 3 days. After the CER was complete, the CER information would be communicated to AJI. If there were any concerns or systemic issues, a CAP would be required. The CAP would be developed by a collaborative group at the facility or at the national level, and would be entered into CEDAR. If the regional director of operations had a concern about the CAP, the QCG would follow-up on any changes to that CAP. No time limits applied to the system service reviews required after other types of events.

When a QCG specialist determined that the quality of an SSR or CER was poor, the concern would be raised on the SRT or addressed and shared with QCG team manager. If the CER or SSR were not corrected, then the QCG would visit the facility and assist with corrective actions. If information obtained from the facility during the SRT was questionable, the follow on “layers” of the process were designed to correct the inaccuracies and improve the quality of the products. During the SRT, the QCG specialist did not ask why the ZFW controllers had not vectored N252G to the closest airport. The QCG expectation was that the facility would work collaboratively with the facility local safety committee (LSC) to investigate and address those

findings or concerns. The makeup of the LSC varied by facility and Mr. Schneider was not sure who were members of the ZFW LSC; he believed ZFW was generally very transparent. Mr. Schneider believed there were layers that would ensure the fidelity of the reported data; Air Traffic Safety Action Program (ATSAP)¹², the CER, the SRT, etc.

Mr. Schneider was not aware that ZFW had not conducted CIC refresher training since 2010. Some of the administrative checklist items in the compliance verification tool may have been removed, and he was not certain if CIC refresher training was still on the checklist. When conducting an ICV, facility inspectors rated the entire checklist, and during an external compliance visit (ECV)¹³ they rated only predetermined items. For any item found on an ICV that was rated as noncompliant, the facility would have the ability to close out that ICV noncompliance item without QCG concurrence or oversight.

When an event was identified as “QCG follow up,” the District office was responsible for ensuring the completion of an SSR or CER. The QCG would work with the district office to ensure the CER or SSR was completed. The QCG SOP identified the requirements of the QCG specialist, but it was more slanted towards the responsibilities of addressing a CAP and not necessarily the responsibilities of following up on an event.

There was a timeframe of three days to complete the CER. Other timeframes or milestone dates were included in the CAP. Items found on an ICV or ECV that were determined to be noncompliant low¹⁴ had no due date or time frame to complete. In the past, the QCG had set an internal expectation that noncompliant low items would be done in 90 days; there was nothing in the national order that addressed time limits.

The CSA Quality Assurance (QA) office was required to monitor all Electronic Occurrence Report (EORs)¹⁵ and Mandatory Occurrence Report (MORs)¹⁶, and provided the QCG with trend information to assist in identifying items of interest. The QCG specialists did not review all MORs out of the assigned district, but did review MORs marked as significant. The QCG monitoring of a specific item was dependent on the item, and the monitoring could be very difficult. The QCG used the mantra “collect, find, fix” as their process for working. QCG had triggers for monitoring special activities. No formal system for categorizing yellow items was identified, but the QCG specialists would discuss items they found in their investigative efforts. There were no formal criteria for a QCG launch; it was both a QCG group manager and director of operations decision.

¹² A confidential, non-punitive safety reporting program for employees in the En Route, Terminal, and System Operations air traffic organizations (ATO). This program is administered by ATO Safety with the participation of NATCA and AOV.

¹³ External assessments of air traffic control facilities conducted every 2 years or as-needed, as determined by the service unit, director of operations at the service area, and/or the QCG.

¹⁴ This finding is assigned to items that are non-compliant but do not represent a significant safety risk to the NAS.

¹⁵ An alert identified by an automated system such as Traffic Analysis and Review Program (TARP) or Operational Error Detection Program (OEDP) that automatically uploads to the Comprehensive Electronic Data Analysis and Reporting (CEDAR) tool.

¹⁶ An occurrence involving air traffic services for which the collection of associated safety-related data and conditions is mandatory.

The QCG kept the director of operations advised of any items found when tasked to do follow-up. Additionally, the QCG reported to the director of operations information on high interest, top 5 identified air traffic issues, or weather CAPs [not inclusive]. The deputy director of operations regularly attended meetings with Runway Safety, QCG, and ATSAP, and remained “plugged in to the process.”

When the National Memorandum of Understanding (MOU) on CAP was written, the Service Center was not given the authority to prescribe or approve a CAP. They did have the authority to suggest changes to CAPs and would be required to request those changes through the director of operations for consideration.

The CSA QCG office conducted 41 ECV’s last year. They had set a goal to visit every federal facility within 3 years. They have begun to work with Kim Curry in AJT to add federal contract towers to the ECVs.

Mr. Schneider said that the QCG office did not request ATSAP data; they would generally ask management leads to work with the ATSAP office to discover if there were any trends. He indicated that he had not made a specific request to see ATSAP data, and was not aware of any specialist that had been denied the use of ATSAP data. Mr. Schneider had been briefed by the ERC that any requests for ATSAP data depended on the intended use of that data.

There was a lot of confusion in the facilities over what constituted a significant MOR. The 1030.3b “Initial Event Response” order provided a list or guide to assist submitters in determining the classification of an event. Mr. Schneider believed his office was properly staffed and equipped to meet the mission of the QCG.

5.10 CSA QCG Specialists

Henry Nagy began with the FAA in August 1982 as a direct hire to Beaumont ATCT, Beaumont, Texas. In 1986, he transferred to Austin ATCT and in 1993 he transferred to DFW ATCT. In 2014, Mr. Nagy transferred to the QCG office where he has remained. His supervisor was Rebecca Plentl.

Mark Clayton began with the FAA in December 1987 reporting to ZME. In 2010, Mr. Clayton transferred to Memphis TRACON, and in 2012 transferred to the QCG office. His supervisor was Steve Phillips.

When an event occurred at any facility within the CSA, the on call specialist on duty would take the initial call and information. They would provide assistance to the facility in the preparation and conduct of the SRT. Depending on the event, ATO safety would assign a risk category to the event; green, yellow, or red. Green indicated there was little or no risk to the event and the operation appeared normal. Yellow indicated there was an identified risk; Mr. Nagy believed that to be “very nebulous.” Red indicated it was a significant event with high risk.

Mr. Nagy indicated the QCG follow up of identified risks was limited to ensuring the CER or SSR were completed. Any additional follow up tended to be with the district office, and was

usually limited to how the facility mitigated the risk. If an event was marked as “Yellow with QCG follow up,” there were no documented steps for “follow up” in the SOP.

After an event that required upward reporting had occurred, an SRT would be conducted to inform the stakeholders of the circumstances. The QCG specialist would have no way of validating the quality of the data being provided by the facility on the SRT. They believed the data was only as good as the person entering it in or providing it. There was a certain expectation that the data would be complete and accurate, and that the facility would be forthcoming with the initial information. Mr. Clayton said they would have a conversation with the facility about the SRT and what questions to expect. Mr. Nagy said that 3 hours to gather data, conduct a cursory investigation, and present the data may be too short depending on the facility and day; weekends are much more challenging.

When there was an aircraft accident, air traffic facilities had 3 days to complete a CER; there was no time limit to complete an SSR. According to Mr. Nagy, QCG specialists do not investigate the facts of a CER or SSR. He noted that SSRs are relatively new to facilities, and that the QCG offers ad hoc assistance to facilities in completing the SSR process. Mr. Clayton indicated that some of the facilities are large and staffed appropriately to conduct a CER or SSR. Many facilities are small and lack the resources to sufficiently conduct the process. In those instances, the QCG would provide a specialist to assist the facility.

When conducting a CER or SSR, the facility would assign a team to conduct the review of the event. Mr. Nagy expected the team to be made up of management, a representative of the union, a representative of the local safety council, and any other individual who may be able to provide insight. He added that he would expect the right group be identified by management for the CER/SSR team. The QCG may participate in the SSR process if they are requested.

Mr. Nagy said the QCG was not involved in the CAP process. The district managers assisted with CAP development, and the QCG office could review it and request changes.

QCG specialists conducted the ECVs at the facilities. He said that evaluations were based on a predetermined list of questions and were generally broken up into 3 categories; operations, training, and administration.

During the last ECV at ZFW, Mr. Nagy had identified that the CIC refresher training was non-compliant. As a matter of coincidence, the same item showed up the same day on a previously completed ICV, indicating the facility was aware of the deficiency and that they were responding to the deficiency. There are no repercussions when a facility self identifies non-compliance via an ICV. Mr. Nagy added that the QCG office had no way of knowing if an ICV was closed satisfactorily until the next ECV was conducted. He believed that 3 days to respond to a “non-compliant high¹⁷” deficiency was too short, and no time limit for a non-compliant low deficiency was too lenient; there should be something in between.

¹⁷ Non-compliant High Risk (NH) – This finding is assigned to items that are non-compliant and represent a significant safety risk to the NAS.

To check the “health” of a facility they are responsible for, Mr. Nagy and Mr. Clayton said they would check the quality of the ICV program. Additionally, if the facility was actually engaged, there would be Operational Skills Assessments (OSAs) data available. If the facility was lacking or if there was evidence of non-compliance, the QCG office had no “teeth” to effect change. They rely heavily on their relationships with facility personnel to effect change; the QCG has no regulatory authority. Both Mr. Clayton and Mr. Nagy agreed that on site visits are extremely important to the success of the QCG.

In attempting to develop safety trend data, Mr. Nagy and Mr. Clayton have made requests for information from ATSAP; those requests are always denied despite the ATSAP order having a provision for sharing that data. They both felt that it amounted to the FAA hiding safety data from itself. Mr. Nagy had been denied ATSAP data so often he no longer requests the data.

Mr. Clayton said the biggest roadblocks to his efforts are a lack of clear expectations of what quality control looked like. He added that only having 9 specialists to cover the entire central United States was difficult. He was on call 72 hours a month, and usually conducted 1 ECV a month in addition to his normal daily activities. Mr. Nagy added that he felt a workforce uneducated on the QA/QC process was a big challenge. As soon as an ATM or facility QC person was up to speed with the QCG mission and process, they would move on and the process at their facility would need to start all over. There was a tremendous amount of turnover in the facilities with little continuity. He also felt FAA Order 7210.634, *Air Traffic Organization (ATO) Quality Control*, was in need of being updated or re-written. Some of the original processes in the order are no longer valid. There was a CSA SOP or common guideline that each of the service areas are now following in the conduct of the duties.

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