

Group Chairman's Field Notes – Attachment 1
Interview Summaries

AIR TRAFFIC CONTROL

CEN22FA070

Interviewee: Benjamin Field
Representative: Mark Tomicich

Date / Time: December 16, 2021 / 0930
Location: Tulsa Air Traffic Control Facility, Tulsa OK
Present: Christopher Fairbanks, Amy Huschka, Sarah Lewis
Investigator: Charles Olvis

During the interview Mr. Field stated the following:

Mr. Benjamin Field began working for the FAA in July 2008 reporting to the FAA Training Facility, Oklahoma City, OK. He graduated from the training facility in September 2008 and reported to San Antonio Air Traffic Control Tower (SAT). In August 2012 he departed SAT and reported to Tulsa Riverside ATCT (RVS). In October 2014 he left RVS and reported to Corpus Christi ATCT (CRP). In May 2017, he left CRP and reported to TUL ATCT. In September 2019 he left TUL and reported to RVS as an Operations Supervisor (OS). He left RVS in December 2020 and reported to TUL as an OS.

Mr. Field's medical certificate was current with no restrictions and did not hold any other aeronautical licenses. He was certified and current on all operating positions at TUL.

Mr. Field's previous ATC experience was with the United States Air Force (USAF). He entered on duty with the USAF in January 2002 and served at Lackland Air Force Base (SKF), Balad Iraq, and Mosul Iraq. He ended active-duty service in January 2008.

Mr. Field's regular days off were Monday and Tuesday. On Wednesday's he worked 1300 to 2100, on Thursday's he worked 1300 to 2100, on Fridays he worked 0700 to 1500, on Saturday's he worked 0700 to 1500, and on Sunday's he worked 0600 to 1400. On the day of the accident, he worked a 0600 to 1400 shift.

On the date of the accident, Mr. Field's said he arrived about 0545. He said that he began working by taking the Radar West (RW) position for proficiency time. He said the weather was good VFR and was clear. He reported the traffic was "extremely light" and that it was a "run of the mill" traffic for Tulsa on a Sunday. After he completed the proficiency time, he assumed the duties as Operations Supervisor.

Mr. Field's said that he could not recall the intricate details of the morning of the accident except that the staffing was better than normal. After staffing the operation, he tasked the remaining controllers with completing training and other administrative tasks.

Mr. Field's said that at about 0900 the traffic was light. He said that he was working as the supervisor from the elevated supervisors console behind the radar displays. He said that he could not remember the exact time, but that he had just sat down and looked at the slaved radar display on the supervisor's console and observed a flashing "ZZ" on the data tag of N3187L. He said that he asked the RW controller what the status of the airplane was, and the controller responded that the airplane had "went into Claremore OK (GCM)". He said he didn't remember the exact words

the controller used but that it was his understanding the airplane landed GCM. Mr. Field's said that he did not contact the GCM airport to inquire about N3187L. He added that he believed TUL radar could see airplanes at about 1,100 to 1,200 feet.

Mr. Field's indicated that he pressed the top left keyboard button that displayed the callsigns of all ADSB equipped airplanes on the radar display. He said that he had observed a target near GCM but that when he pressed the button on the keyboard the target near GCM did not display the callsign data for the track flashing ZZ (N3187L). The RW controller indicated the target near GCM wasn't the missing airplane and that N3187L had landed before the target.

Mr. Field's said that he stood up to walk away and heard the controller "reach out" to N3187L and terminate radar service. Mr. Field's said that he was not monitoring the frequency. He added that it would have been more correct for the RW controller to advise the pilot that radar contact was lost rather than terminating radar service.

At around 1115 local, Mr. Fields became aware of an aircraft accident east of TUL. An off-duty air traffic controller who was also a volunteer firefighter called the facility and advised they were responding to an aircraft accident and asked Mr. Field's if he was aware. About 15 to 20 minutes later the off-duty air traffic controller called back with a callsign of the downed airplane.

Mr. Field's said he used the Falcon replay tool and reviewed the traffic; he said that he realized TUL had worked the airplane. He said that when he reviewed the Falcon it jogged his memory about N3187L and the data tag displaying ZZ. He said that he did not tell the RW controller about the accident immediately, however when he did tell him the RW controller indicated he already knew about it. They reviewed the Falcon data again and then Mr. Field's began making all the required notifications. He said that he was very busy and that he could not remember the conversation with the RW controller exactly. Mr. Field's said that he completed the accident and incident notification checklist and contacted the Air Traffic Manager (ATM) who came in and assisted with the initial notifications.

Mr. Field's said that it was not uncommon for VFR airplanes to go off frequency by themselves and proceed to an airport without notifying TUL ATC. He said that a lot of times pilots will go off frequency, do a touch and go at an airport, and then contact TUL for additional services. Mr. Field's stated that under normal circumstances airplanes in the vicinity of GCM can either drop off the radar display or go into a ZZ status. He said there was no local procedure for when an airplane leaves the frequency with no notice and that it was not a trigger to indicate there was an issue with the flight. However, he indicated he would sometimes call the airport manager to try and locate the missing airplane.

Mr. Field's said that he was familiar with the requirements for when an air traffic controller experienced a simultaneous loss of radar contact and communications. He indicated that he would reference the FAA Job Order (FAA JO) 7110.65 Air Traffic Control for the Alert Notice (ALNOT) procedures.

Mr. Field's indicated that when working the OS position, he normally worked it from the terminal radar approach control (TRACON) supervisors' position. He said that the control tower was normally staffed with a controller in charge (CIC). The normal facility staffing configuration was the radar west position and the OS in the TRACON, and local east in tower and ground control (GC) combined with clearance delivery (CD) and CIC. Mr. Field's said they would sometimes split off CIC in the tower but only during training. He said that there were 5 operating positions in the radar room. The supervisor "perch" was a standard set up with equipment, but controllers could use their own preference sets into the Standard Terminal Automation Replacement System (STARS) slave display.

Mr. Field's said that when N3187L had initially tried to depart TUL and had an engine issue, the control tower did not advise the RW controller. He added that it was not common for the tower controllers to put VFR flight plan information into the Flight Data Input/Output (FDIO). He added that it was normal for radar controllers to not ask if a pilot wanted a flight to be put into the FDIO. A few controllers would ask a VFR pilot for their destination but that it was not required.

Mr. Field's indicated that the RW controller was trustworthy but that he was not the strongest controller in the facility.

Mr. Field's said there had been a Covered Event Review (CER) conducted on the accident flight. He indicated the CER revealed that the ALNOT procedures were not followed by the controller and the controller had not alerted the OS of the simultaneous loss of communications and radar contact. He said that it was his expectation that when a controller did lose communications and radar with an airplane that they would notify the OS immediately.

Interview concluded at 1020.

Interviewee: Jonathon Burton
Representative: Jason Perkins

Date/Time: December 16, 2021 / 1105 CST
Location: Tulsa Air Traffic Control Facility, Tulsa OK
Present: Chris Fairbanks, Amy Huschka, Sarah Lewis
Investigator: Charles Olvis

During the interview Mr. Burton stated the following:

Mr. Burton began working for the FAA in November of 2015 as a direct hire from the FAA Training Facility, Oklahoma City, OK. He graduated from the training facility with the Basic and Enroute Class in April of 2016 and reported to Seattle Center (ZSE). He was certified on one D side and then filed for a hard-ship transfer to TUL in February of 2017. He is qualified on all operating positions in the tower and terminal radar approach control (TRACON) and was designated a Controller in Charge (CIC).

Mr. Burton had a current medical certificate with no restrictions. He held no additional certificates.

Mr. Burton's regular days off (RDO) were Sunday and Monday. On Tuesdays he worked a 1445 to 2245 shift, on Wednesdays he worked a 1300-2100 shift, on Thursdays he worked a 0700 to 1500 shift, on Fridays he worked a 0700 to 1500 shift and on Saturdays he worked a 0600 to 1400 shift. Mr. Burton was on an overtime (OT) shift on the Sunday of the accident. He came in on a 0600 to 1400 shift. He had routinely been working a six-day work week throughout the year.

On December 12, 2021, Mr. Burton signed in for his OT shift at 0545 and then listened to the weather briefing and checked CEDAR for any Read and Initial (R&I) items, then reported for duty. Mr. Burton opened the radar west position (RW) as they were in the overnight configuration in the tower. He worked for about 10 minutes when the Operations Supervisor (OS) came in to get proficiency time. Mr. Burton went on break and then resumed the RW position around 0900. The weather was VFR and traffic was slow.

Mr. Burton stated that when N3187L departed TUL he received a flight progress strip from the ATCT via the tower drop tube. The flight progress strip indicated the airplane was a VFR departure to the east. The aircraft came off on a 090 heading. When N3187L checked in, Mr. Burton asked the requested altitude and the pilot advised 9500'. Mr. Burton stopped him at 3000' for traffic passing over at 4000'. He exchanged traffic and when they passed, Mr. Burton told N3187L traffic was no factor, climb to requested altitude. He was getting ready to terminate radar flight following at the 20-mile range ring. Mr. Burton noted no conflicts for N3187L and shifted his priorities to a sequence at TUL and an aircraft at Riverside (RVS).

Mr. Burton stated that he saw in his peripheral that the aircraft turned northeast toward Claremore (GCM) and that's not uncommon. He once again shifted his attention to the TUL finals. When he looked back, the track was in a coast status, but he observed a primary target over GCM and assumed it was N3187L. He last saw the aircraft climbing out of 5000'. He stated he never saw the aircraft in a descent. When asked if this was an unusual situation he stated, "we get test pilots out here who will climb up and drop back down and maneuver in the area." The operations supervisor (OS), Ben Fields, came over to talk to him but was at another scope, possibly Satellite East position, about the time Mr. Burton saw the primary target. He was not sure what the OS did at that time. Mr. Burton reached out to the aircraft with no response so just gave the blanket response, "Radar service terminated, frequency change approved." Mr. Burton doesn't recall the OS saying "that's not the guy" in reference to the primary target. He continued to work traffic as normal.

Mr. Burton has since studied 7110.65 10-3-1b which states to issue an alert notice (ALNOT) in the event of a simultaneous loss of radar and communications. He didn't think to say radar contact lost because aircraft often pop back off GCM and then he educates them that they need to let ATC know when they leave the frequency.

Mr. Burton was asked what he would see in a normal situation where an airplane leaves the frequency with no notification. After conferring with the National Air Traffic Controllers Association (NATCA) representative he responded he could see an aircraft down to about 900'.

Mr. Burton was not sure if you would see at least a primary target going into GCM. He also stated you would normally see a tag in coast over or near the GCM airport.

Mr. Burton was asked about National Airspace System (NAS) VFR flight plans; he stated that the tower doesn't normally solicit flight following and will often use local codes. He stated that he was waiting until he got ready to terminate radar service to the airplane, around the 15-20 mile range ring, to offer additional services and enter a flight plan into the NAS.

Mr. Burton stated that when he shifted his attention away from N3187L, he was watching the TUL traffic. He felt his job with a VFR was to provide any traffic in the area and any other requests that were made. He stated there was nothing else he could provide for the airplane once he cleared the traffic that was exchanged and N3187L was advised to climb to his requested altitude. Mr. Burton felt that, from his viewpoint, a simultaneous loss of radar and communications was a common occurrence and he saw no red flags.

Mr. Burton was asked how he learned of the accident and said that a fellow controller, who was also a volunteer fire fighter, called the facility when he responded to the crash site. He talked to the OS and Mr. Fields came into the breakroom to ask him about it. He stated he still didn't think it could have been N3187L at the time.

Mr. Burton was interviewed in the Covered Event Review (CER).

Interview concluded at 1145.

Interviewee: Joshua Rogers

Representative: Mark Tomicich

Date / Time: December 16, 2021 / 1400 CST

Location: Tulsa Air Traffic Control Facility, Tulsa OK

Present: Chris Fairbanks, Amy Huschka, Sarah Lewis

Investigator: Charles Olvis

During the interview Mr. Rogers stated the following:

Mr. Rogers began working for the FAA in March 2003 and reported to Abilene ATCT (ABI). In June 2005 he left ABI and reported to Seattle TRACON (S56). In January 2008 he left S56 and reported to Chicago TRACON (C90). While in C90 he was promoted to OS. He left C90 in November 2014 and reported to Corpus Christi ATCT (CRP) for duty as an Operations Manager (OM). He left CRP in April 2016 and reported to TUL for duty as the ATM.

His prior ATC experience was with the USAF. He joined the USAF in November 1993 and graduated USAF Air Traffic Control School in May 1994 and reported to Laughlin AFB (DLF) in Del Rio Tx. In July 1998 he left DLF and reported to Thule AFB in Greenland (BGTL). In July 1999 he left BGTL and reported to Grand Forks AFB (RDR) in Grand Forks North Dakota. He departed active duty and joined the Department of Defense as a civilian air traffic controller at RDR and left in March 2003 to join the FAA.

Mr. Rogers did not have an aviation medical, nor was he required to. He did not have any additional aeronautical licenses. His regular days off (RDO) were Saturday and Sunday, and his weekly schedule was normally Monday through Friday 0630 to 1530.

Mr. Rogers received notification of the accident on Sunday December 12th at 1103 am. The OS reported that an off duty TUL controller and volunteer firefighter had responded to an aircraft accident and reported the accident to the facility. Mr. Rogers stated that the off-duty controller asked, "How many bodies are we looking for?" Mr. Rogers told the OS to call the off-duty controller back to obtain the aircraft N number, the the OS could start his investigation to see if the facility had worked the aircraft. About 30 minutes later the OS called Mr. Rogers back and confirmed that the facility had indeed worked the aircraft.

During the time that the facility waited for confirmation of the N number, the OS attempted to load the Falcon replay to review track data; this took about 30 minutes. The OS notified Mr. Rogers that the facility had worked the aircraft, but an ALNOT was not issued because the facility did not realize that the aircraft was missing. Mr. Rogers told the OS that he was, "on his way in."

Mr. Rogers called the support specialist on his drive into the facility. He asked the support specialist to start collecting all data needed for the Services Rendered Telcon (SRT). Mr. Rogers arrived at the facility, went directly to the TRACON and assisted with the completion of the accident package. He then checked on the data collection from the support specialist who had arrived at the facility to assist. The support specialist obtained the voice recording. Mr. Rogers stated that the OS had been tasked to complete the MOR to handle a public inquiry. He said that he assisted the facility for about 6 hours to obtain the required information to conduct the SRT. Mr. Rogers said that there had been a determination not to conduct a drug test on the RW controller.

Mr. Rogers stated that his impression of the way that the aircraft was handled was "not acceptable." That the service had been "lacking" to allow the "target to disappear at 4700 feet and not follow up." He added that it was the expectation of the FAA to issue traffic advisories and provide safety alerts as directed by FAA JO 7110.65 Basic radar Services. Mr. Rogers was asked if it was his expectation that if there was no traffic for an aircraft if it was ok to divert the controller's attention from that aircraft? He answered, "No." He stated that he expected a controller to "scan, re-evaluate, scan and re-evaluate." He stated that he believed that the RW controller was watching the TUL finals and had been waiting for a base turn on one of the airplanes which diverted attention away from N3187L.

Mr. Rogers asked the OS why there was no follow up at the time. The OS stated he had walked down to the radar scope and pushed the quick look function button.

A CER was conducted two days later, Tuesday, December 14 due to the mandated RDO of the RW controller. The RW controller was asked to report for duty earlier than his scheduled evening shift to participate. During the interview, the RW controller stated that he had believed that an unidentified aircraft in the vicinity of Claremore, OK (GCM) was the subject aircraft. Mr. Rogers stated that the RW controller did not say whether he had pushed the "beacon all" button.

After the STARS replay was reviewed it was noted that the RW controller had pushed the “beacon all: button ten times.

Mr. Rogers stated that it was not unusual for an aircraft to turn north and leave the frequency as had happened in this accident.

Mr. Rogers stated that he had been briefed about the RW controllers progress during his training. He stated that he felt that the RW controller had been lazy and unmotivated. Mr. Rogers shared information about the RW controllers Tower Basics class in Oklahoma City when he had skipped the last two to three days of the class calling out sick. When asked why the RW controller had not attended the last few days of class, Mr. Rogers recalled that the RW controller responded that he had not needed to be there since the class wasn’t graded. The RW controller decided to return home instead.

Mr. Rogers stated that he could not recall issues in the RW controllers training that regarded either scanning or unusual situations. Mr. Rogers stated that all controllers at TUL were trained to recognize unusual situations.

Mr. Rogers admitted two instances that the RW controller had received Performance Record of Conversations (PROC). He stated the PROCs were not positive but that the PROCs were intended to motivate the RW controller to get better.

Mr. Rogers was asked if the RW controller had undergone skill enhancement training. Mr. Rogers stated that most controllers go through skill enhancement training at some point but that he doesn’t recall if the RW controller had experienced it or not.

Mr. Rogers stated that the RW controllers’ performance of duties as an air traffic controller, given his time of service in the agency, and time as a certified professional controller (CPC), had been average for a young person; but the training process had been slower. He believed that the RW controller was often misread, and stated that his body language and voice may indicate a lack of urgency. However, Mr. Rogers did not believe this to be accurate. Mr. Rogers reported that the RW controllers peers believed that he wanted to get better, and they believed he was trying. Mr. Rogers believed that “the light came on” Tuesday when the RW controller was interviewed during the CER. The RW controller showed that he had a different sense of urgency. On the day of the accident, Mr. Rogers believed that the RW controller was more focused on the outcome rather than the process.

Mr. Rogers stated that he intended to implement a Corrective Action Plan (CAP) that addressed what the facility had missed with the handling of the accident airplane. He wanted to wait until he received feedback from the investigative process to include what was uncovered during the investigation into the CAP.

Mr. Rogers finished the interview by stating that he told his controllers, “others can learn from this. This is why these things matter. You might want to pay attention, you never know when you may need it.”

Interview concluded at 1450 LCL.