

Factual Report – Attachment 1

Interview Summaries

AIR TRAFFIC CONTROL

ERA16FA035

Interviewee: Ashley Candler
Rep: Greg Shoemaker – NATCA Attorney
Date: November 14, 2015
Location: Tallahassee Air Traffic Control Tower (TLH ATCT)
Present: Paul Suffern – NTSB, Jack Clark – FAA, Eric Stormfels – NATCA
Investigator: Brian Soper

During the interview, Ms. Chandler stated the following:

Her air traffic control experience began in April of 2014 at the FAA Academy in Oklahoma City, Oklahoma. After successful completion of initial air traffic control training, she was assigned to TLH ATCT in June of 2014.

Her regular work schedule was a rotating shift schedule with regular days off on Thursday and Friday. Her work schedule for the week leading up to, and the day of the accident was:

Tuesday	0700 - 1500
Wednesday	0700 - 1500
Thursday	Off
Friday	Off
Saturday	1300 - 2100
Sunday	1300 - 2100
Monday	0700 - 1500 (Day of accident)

She was training on the radar east position (RE-DEV) at the time of the accident. She had no suspensions or documented operational incidents while at TLH. She held no collateral duties, and had not been on any recent details. She recalled nothing remarkable about the 72 hours leading up to the time of the accident, which consisted of her normal daily routine, sleep, and meals.

Her operating initials were AG and her supervisor was Ken Ifland. She possessed a current second-class medical certificate and her last ATC physical had been conducted in July of 2014. She had a restriction to wear corrective lenses while performing air traffic control duties and said that she was wearing them at the time of the accident. She had no other waivers or restrictions to her medical certificate. She possessed a degree in air traffic management from Embry Riddle Aeronautical University, and held no other aeronautical ratings or certifications.

On the day of the accident, she was working her normally scheduled shift. She said the facility had been having automation problems, and also remembered from being on ground control in the tower earlier, that the facility was on generator power. She recalled the weather being marginal VFR with a ceiling of 1,000 feet and a scattered layer she thought was at about 500 feet. She said it had been IFR all morning with thunderstorms in the vicinity and lightning to the northeast. She had reviewed the audio and video replay of the event during her FAA pre-brief just prior to the interview. She was training at the time of the accident and was being monitored by her primary instructor. On a scale of 1 to 5 (5 being the heaviest) she classified the traffic load as 1 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) she classified the traffic complexity as 3 at the time of the accident. She said that a relief briefing was conducted when she

assumed the position, and that it was recorded, but could not recall if the checklist was utilized. She stated that she did not file an air traffic safety action program (ATSAP) report as a result of this accident.

When she first took the position she recalled having an overflight to the northwest that kept dropping the radar data tag, and she was trying to take care of that. She remembered being briefed that the pilot of N164GP had already terminated his IFR and was continuing VFR to 70J, but he was still tagged up so she manually dropped the tag. Her instructor taught her that "if you're not talking to them, drop the tag", so she did. She was working two other aircraft; a Tacoma that she had vectored to the RNAV at TLH, and a Blue Streak that she had vectored for the ILS at TLH.

When the pilot of N164GP first called her, he called "center", so she assumed he had come up the wrong frequency. She instructed the pilot to try his last assigned frequency because he was up TLH (she explained that this was common, as there was a like frequency between TLH and JAX, one was 128.7 and one was 127.8). The pilot then stated that he had lost visual on the 70J and wanted the RNAV approach to runway 13 at TLH. She recalled this being the same aircraft from earlier that the off-going controller had told her about, which her instructor said it was N132GP, so she was looking through the closed out strips to find his original and could not find it. Her instructor then told her to just type in a local IFR flight plan, which she did, and hand-wrote a flight strip. When asked why she had not issued the altimeter to N164GP, she said it was rather ironic because she had been told that she issued the altimeter too often, and was trying to cut down on the number of times she issued it.

She was still working her other aircraft, and recalled switching one to another facility, but her focus was mostly on N164GP because she was concerned about the MVA in the area the pilot was flying and the potentially conflicting traffic that she had approved a point out on with Valdosta approach. Therefore, she issued the pilot of N164GP a westbound heading of 270, in order to get him on a downwind or runway 13, and instructed him to maintain 3,000 feet. She said that the pilot continued to fly toward 70J and had not turned to his assigned heading of 270, nor was he maintaining 3,000 feet, which was when Valdosta called to inquire about what N164GP was doing. Her instructor told Valdosta that they were taking him west at 3,000 feet, after which, he immediately instructed the pilot of N164GP to turn left to 270 for traffic, at which time she observed the aircraft started turning immediately on her display. N164GP was still not at his assigned altitude, so her instructor issued the altimeter and asked the pilot of N164GP what was his altitude. When the pilot of N164GP reported that he was level at 3,000 feet, her instructor told him to discontinue his altitude squawk because it differed by 500 feet, but the pilot never stopped squawking altitude. A few minutes later N164GP reported level at 3,000 feet and it matched what was shown on her display.

She said that the pilot could not find the OCAPE fix, and even remembered spelling it out for him at one point. He was still having trouble finding the fix, and she was concerned the pilot may have the wrong approach entered, so she reiterated that he was on the RNAV to runway 13 and not runway 31. He still could not find the fix, so she instructed him to turn right to a 310 heading, then told her instructor she was just going to vector him for the approach, which her instructor said that was fine. She was still working other traffic and remembered the pilot of

N164GP calling back at some point saying he had found the fix, and she could see on her display that he was just south of OCAPE, so she cleared him for the approach.

She then continued working the other aircraft that were going into TLH and another overflight that had checked in. Her instructor told her to make sure that she gave the cancellation instructions to N164GP, which she did, but the pilot did not respond. Her instructor then said to try him again, which she did, and again the pilot did not respond. She then noticed that the radar data tag showed "z's", which she said happened when a tag was dropped. She did not think much of it at the time due to the problems they had been having with other aircraft dropping tags that day, and assumed it was just another occurrence like that. After the pilot still had not responded to additional attempts to contact him, she told the radar controller in-charge (RCIC) that she had lost radar and radio communications with N164GP. The RCIC asked where the aircraft was last seen, and though she unable to give precise coordinates, she stated that his last position was about 13 miles west of 70J.

She recalled taking a call from flight service, who asked if she wanted assistance; but it had only been about 15 minutes at that time, therefore declined. That was the only interaction she had with the search phase of the accident. She remained on position until the top of the hour, took a 20 minute break, then signed onto ground control (combined with flight data and clearance delivery) in the tower, for about 1.5 hours. She was not aware there had actually been an accident until about 1600 EST when her supervisor called to inform her the wreckage had been found.

She recalled hearing the low altitude alarm sounding, and when she looked at her scope she did not see anything on there that corresponded with that alert. She said sometimes the technicians would test the alarms, and they just sound a couple of times and then quit. Since she did not see a visual alert on her display, she assumed that was what had happened in this case.

With regards to PIREP solicitation and dissemination, she knew that the weather conditions at the time required her to solicit PIREPs, and said she did solicit one from a Delta pilot, but it was much later. She did not recall the RCIC ever asking her to solicit PIREPs. Her initial training was very big on PIREPs, not only solicitation but also dissemination. She said the process at TLH, when she would receive a PIREP, was to write the information on a blank flight strip or piece of paper, then call and pass it to Lockheed Martin Flight Service (LMFS), or give it to the (R?)CIC who would call it in. They would sometimes have trouble getting through to LMFS, saying it would just ring and ring, but more often than not, they would get ahold of somebody. She said they received PIREPs via the flight data input/output (FDIO), and sometimes Jacksonville ARTCC (ZJX) would call with them. She had seen the PIREP forms, but they had only recently been made available at TLH ATCT. She said that PIREP training, in her initial training, was pretty good and that actually, it was a big deduction in your performance grade if you forgot to solicit them during a P-run (simulated progress check). She said that at TLH ATCT, PIREPs were primarily used for local operations and she felt that the facility was pretty good about getting PIREPs out to other aircraft they were working, but maybe they were not so good at dissemination outside of the facility.

When asked how she would characterize the interaction with the accident pilot, she said that based on the type aircraft he was flying, she felt that he must have had decent experience. She

said the pilot sounded very calm, but she felt he just did not seem to “have it all together”. She said the weather was not great and he seemed to have other motives other than what ATC had planned for him, he just seemed “squirrely”. She also knew that Sarah (the controller that she had relieved) was not real comfortable with switching him when she did, but the pilot wanted to go. When the pilot first called back up for services, she wondered what he had been doing down there low and nowhere near the airport. He sounded like an experienced pilot, but something just did not seem right. She never got the feeling he was in an emergency situation, and actually felt it was more like he was just intent on getting into 70J visually.

She recalled that she had a hand written flight strip on N164GP, and was pretty sure she had been the one to write it. The only thing her instructor wrote on the strip was probably the time they lost communications with the pilot.

Interviewee: John Lopez
Rep: Greg Shoemaker – NATCA Attorney
Date / Time: November 14, 2015
Location: THL ATCT
Present: Paul Suffern – NTSB, Jack Clark – FAA, Eric Stormfels – NATCA
Investigator: Brian Soper

During the interview, Mr. Lopez stated the following:

His air traffic control experience began in the United States Navy where he served as an air traffic controller from 1992 to 1999. In December of 1999, he was hired under the Veterans Recruitment Appointment (VRA) direct hire program at Monroe ATCT (MLU). He remained at MLU until January of 2004 when he transferred to Reno ATCT (RNO) and worked until January of 2010 when he transferred to Central Florida TRACON (F11). In August of 2014 he transferred to TLH ATCT.

His regular work schedule was a rotating shift schedule with regular days off on Thursday, Friday, and Saturday. His work schedule for the week leading up to, and the day of the accident was:

Tuesday	0800 - 1800
Wednesday	0545 - 1545
Thursday	Off
Friday	Off
Saturday	Off
Sunday	1315 - 2015
Monday	0815 - 1815 (Day of accident)

He was the instructor (RE-OJTI) monitoring the RE-DEV controller at the time of the accident. He was certified on the RE position in October of 2014, and was current and proficient on the position he was working at the time of the accident, in accordance with facility standards. He had no suspensions or documented operational incidents while at TLH ATCT. He was on the TLH Safety Committee and had been working on the new standard operating procedures (SOP). He had not been on any recent details. He recalled nothing remarkable about the 72 hours leading up to the time of the accident, which consisted of his normal daily routine, sleep, and meals.

His operating initials were JP and his supervisor was Ken Ifland. He possessed a current second-class medical certificate and his last ATC physical was conducted in April of 2015. He had no waivers or restrictions to his medical clearance. He did not possess a college degree, and held no other aeronautical ratings or certifications.

On the day of the accident, he was working his normally scheduled shift and recalled that they had been having automation issues around the time of the accident. He recalled the weather at the time of the accident was low IFR with low ceilings. On a scale of 1 to 5 (5 being the heaviest) he classified the traffic load as 3 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) he classified the traffic complexity as 4 at the time of the accident (these values were as

they applied to the developmental controller). He said that a position relief briefing was conducted when he assumed the position, a checklist was utilized, and it was recorded. He stated that he did not file an ATSAP report as a result of this accident.

When he and the developmental controller took the position, the developmental conducted the position relief briefing with the controller being relieved. Traffic was routine and he did not recall much leading up to the time the pilot of N164GP called up. He said they were having automation issues with aircraft not tagging up properly, specifically recalling a “pop up” looking for an IFR clearance to the southeast, and another aircraft about 20 miles northwest of THL. He could not remember if that had been before or after the pilot of N164GP called up requesting an IFR clearance.

When the pilot N164GP first called up, the last two letters [GP] sounded familiar, and he figured it was the same pilot that had cancelled IFR before they assumed the position, and when the pilot said he had lost visual on the airport that reaffirmed his presumption. He recalled that the developmental had put N164GP on a 270 heading and had instructed the pilot to maintain 3,000 feet, due to traffic at 4,000 feet that had been previously pointed out by Valdosta approach. He remembered observing N164GP climbing and descending, and the developmental was going back and forth with other traffic trying to work out the automation issues, so he interjected and instructed N164GP to maintain 3,000 feet and turn left to 270. He said that he issued the altimeter and asked the pilot N164GP for his altitude and the pilot said 3,000 feet, but his tag indicated 2,500 feet, so he told him to stop his altitude squawk because it differed by 500 feet. The pilot however, never stopped his altitude squawk. Later, the pilot reported being level at 3,000 feet, which corresponded to the altitude displayed in his radar data tag. He said when he saw the altitude on N164GP changing up and down, he was afraid they (THL) were having more automation problems since they had already had at least two previous issues related to automation.

He said the pilot of N164GP asked for the RNAV/GPS runway 13 approach into 70J, and he was not sure if it was then, but at some point the developmental controller had issued the pilot a 330 heading, and instructed him to expect OCAPE. The pilot said that he could not find OCAPE so the developmental controller spelled it out for him. After a few more transmissions the pilot had asked for a fix that was not on the RNAV runway 13 approach, so he told the developmental to just put N164GP on a 330 heading at 3,000 feet because that would keep him clear of conflicts and keep him going in the right direction.

He could not recall which aircraft the developmental was talking to, but she was sequencing aircraft into TLH, when he realized that the developmental had not re-cleared N164GP, so he went ahead and cleared the pilot of N164GP to 70J. Once N164GP was a little closer, the developmental controller said she was just going to put N164GP on the downwind and vector him to final. Then the pilot of N164GP said that he had found OCAPE, so the developmental controller cleared N164GP for the RNAV approach to runway 13. He remembered sometime after that the developmental had cleared N164GP, then he observed the target at 2,500, 2,700, or 2,900 feet, he could not remember exactly, but knew it was lower than the assigned altitude of 3,000 feet. He got a quick glimpse of the target before it went into “coast” just north of OCAPE. He reminded the developmental to issue cancellation instructions to the pilot of N164GP, because of weak radar and radio coverage in that area, which she did; however the pilot did not respond

He recalled that 15 to 20 minutes after they had lost radio communications and radar contact with the flight, he notified the RCIC because he did not want to wait an entire 30 minutes for the pilot to cancel. He did not feel that there was an emergency situation with N164GP; he really just thought the pilot might forget to actually cancel his IFR, or would not take the time to call in the cancellation, as would often occur.

He did not remember any of the traffic after that. He did, however, know stuff was going on behind him because he heard Sarah [the RCIC] saying she was concerned that the airport operators (70J) had not seen or heard from the accident aircraft. He then told the developmental to go ahead and take a break because the RCIC was busy. By that time, the ATM had arrived in the radar room and was helping the RCIC with phone calls and coordination in attempts to locate N164GP. He continued to work the position alone while others continued to make phone calls in the back, until another controller was assigned to relieve him.

He did not recall hearing any low altitude or conflict alerts alarming while working that day. He said however, that if he was not talking to an aircraft, it was his technique to drop the tag. He was not sure if the RE-DEV controller had done it that day, but said it was his normal practice.

Compared to other pilots, he said that he would have expected a little more ATC compliance from someone flying that type of aircraft, and that he would be more prepared for the approach he was requesting. He never perceived that there was an emergency situation, but based on his interaction with the accident pilot, he felt the pilot's abilities were not great, which was the reason he had the RCIC call to confirm his arrival. The plan was to just vector N164GP when the pilot could not find the fix. He said it was his gut feeling that they were going to get N164GP back for another approach, or the pilot was going to circle or land, and not call with his cancellation. He felt that the pilot would just "space them out" or ignore them again.

He said that radio communications and radar coverage near 70J was spotty and that it was normal to lose radar and/or radio communications below 3,000 feet. He said he would have normally issued a "radar contact loss" to N164GP, but in this case it had not been done.

With regards to PIREP solicitation and dissemination, he said he knew that the weather conditions at the time required that PIREPs be solicited, and that it was his normal practice to solicit and get them to the tower ASAP because they had their eyes on everything. Normally, he would solicit at least one PIREP per hour or anytime there was a significant change in the weather. He said that he would call LMFS himself to pass PIREP information if he had the time, and to tower or radar as well. He would normally just use a blank flight strip to copy down the PIREP information, but recently [since the accident] they had been provided PIREP forms for use in taking down PIREP information for further dissemination.

He did not have much to do with the search phase of the accident. He said that once he saw the tag go into coast, he passed a position with reference to OCAPE, to the RCIC. He took a break a little later, and then went to work in the tower until he was relieved. He felt that something was definitely wrong once N164GP had been missing for over an hour, but he did not know there had definitely been an accident until later that day when he was informed the wreckage had been found.

Interviewee: Sarah Rud
Rep: Greg Shoemaker – NATCA Attorney
Date / Time: November 14, 2015
Location: Tallahassee Air Traffic Control Tower (TLH ATCT)
Present: Paul Suffern – NTSB, Jack Clark – FAA, Eric Stormfels – NATCA
Investigator: Brian Soper

During the interview, Ms. Rud stated the following:

Her air traffic control experience began in the United States Air Force where she served as an air traffic controller from 2002 to 2006. In November of 2012 she was hired by the FAA and attended the FAA Academy in Oklahoma City, Oklahoma. After successful completion of initial training she began working at TLH ATCT in January of 2013.

Her regular work schedule was a rotating shift schedule with regular days off on Tuesday, Wednesday, and Thursday. Her work schedule for the week leading up to, and the day of the accident was:

Tuesday	Off
Wednesday	Off
Thursday	Off
Friday	1315 - 2315
Saturday	0900 - 1700
Sunday	0800 - 1800
Monday	0545 - 1545 (Day of accident)

She was the RCIC at the time of the accident. She was certified in April of 2015 and was current and proficient on all positions for which she was certified. She had no suspensions or any documented operational incidents while at TLH ATCT. She was on the TLH Safety Committee and had been working on the new SOP. She recalled nothing remarkable about the 72 hours leading up to the time of the accident, which consisted of her normal daily routine, sleep, and meals.

Her operating initials were SR and her supervisor was Erwin Beavers. She possessed a current second class medical certificate and her last ATC physical was conducted in May of 2014. She had no waivers or restrictions to her medical certificate. She possessed a degree in accounting from the University of Phoenix, and held no other aeronautical ratings or certificates.

On the day of the accident, she was working her normally scheduled shift and recalled they were having some automation issues with data tags dropping, and that mode S was “in and out.” She recalled the weather was IFR. She had reviewed the audio and video replay of the event during her FAA pre-briefing just prior to the interview. Training was being conducted on the radar east position at the time of the accident. On a scale of 1 to 5 (5 being the heaviest) she classified the traffic load as 2 at the time of the accident. On a scale of 1 to 5 (5 being the most complex) she classified the traffic complexity as 4 at the time of the accident. She said that a position relief briefing was not conducted when she assumed the position, because she opened the position for the day. She filed an ATSAP report as a result of this accident.

She had been RCIC the entire time services were being provided to N164GP, and had initially worked the accident aircraft upon initial contact with TLH ATCT. When she had initially worked N164GP, she had received a call from ZJX with a point out on an aircraft that was descending to 4,000 feet and deviating left for weather, which she approved. Shortly after that, the pilot of N164GP checked in, and she asked his intentions at 70J. The pilot responded that he wanted to get lower to get 70J in sight visually. She informed the pilot that there was no weather available for 70J, but that TLH and BGE were both IFR, and the pilot said he would do the RNAV to runway 31 at 70J. She looked at the RNAV runway 31 approach procedure and instructed the pilot to proceed direct to Greenville (GEF) for the RNAV approach to runway 31. She then instructed the pilot of N164GP to descend and maintain 3,000 feet, correcting herself to 3,200 feet. The pilot then asked if Greenville was “GES” and she told him no, it was “GEF.” N164GP was then flying toward GEF, which she believed she cleared him for the approach, when the pilot responded back and said he had the airport in sight and wanted to proceed visually. She instructed the pilot to report the IFR cancellation in the air on her frequency, or on the ground via flight service, or TLH ATCT via telephone. The pilot then stated he would cancel, even after she suggested he could remain with her for VFR advisories to 70J, and said he was switching to UNICOM¹ at that time. She then saw John and Ashley [the RE-OJTI and RE-DEV] coming in to relieve her. She then instructed the pilot of N164GP to squawk VFR, to which she received no response. She also transmitted that radar services were terminated, and again received no response from the pilot. She told John and Ashley all about N164GP during the position relief briefing, and after being relieved, she went to the supervisor’s desk to continue working other RCIC duties.

While working on other RCIC duties, she heard the pilot of N164GP call back up for services and heard the RE-DEV controller issue a 270 heading and altitude to maintain of 3,000 feet. She also recalled Valdosta approach calling with a point out on an aircraft descending to 4,000 feet going to YALMI intersection. She then started monitoring both the RE-DEV and RE-OJTI controllers and heard the RE-OJTI controller issue the pilot of N164GP a 270 heading and the altimeter. She recalled asking the RE-OJTI controller if N164GP had been re-cleared to 70J and he said no, and then he cleared him to 70J via radar vectors. She recalled them [RE-OJTI and RE-DEV] trying to get the pilot of N164GP to proceed to the initial approach fix of OCAPE, however, the pilot was having trouble locating it, and was getting the runway 13 and runway 31 approaches confused. She then told the RE-DEV controller to make sure the pilot of N164GP was looking at the RNAV runway 13 approach and not the RNAV to runway 31. She remembered the pilot asking for the spelling of OCAPE, and sometime later was finally able to locate the fix.

Once the pilot of N164GP had located OCAPE, the RE-DEV controller cleared him for the approach and instructed him to maintain at or above 3,000 feet, then immediately correcting herself to at or below 3,000 feet. Shortly after observing N164GP over OCAPE, the radar data tag went into “sleep mode” or “coast.” She recalled the RE-DEV controller instructing the pilot of N164GP to report his cancellation of IFR in the air on her frequency, on the ground via flight service, or facility via telephone, however there was no response from the pilot. The RE-OJTI and RE-DEV controllers continued to work the position, and she continued to work on logs at the supervisor’s

¹ UNICOM – (Universal Communications) A nongovernment communication facility which may provide airport information at certain airports.

desk. About 20 minutes later someone asked her if she had received a call, or if she could call the airport to see if N164GP had landed.

She then began calling around to see what she could find out. First, she called LMFS, who said they had not received a cancellation on N164GP. She then attempted to call the airport manager at 70J, followed by the city manager, but there was no answer from either. She said by that time, 30 minutes had passed and LMFS called back saying they had a phone number for the pilot and asked if she needed any help. She called the pilots phone, and it rang twice and then went to voicemail, so she left a message. Then she immediately called the pilots phone again, and that time it went directly to voicemail without ringing. She received another call from the specialist at LMFS, who stated they had been in touch with the airport manager and the airplane was not there, and that there were two passengers there waiting to be picked up by N164GP.

She then went to see the ATM and inform him about the situation, not knowing exactly what she should do. The ATM instructed her to call ZJX and LMFS to get an ALNOT issued, and then call the ROC (regional operations center.) After she had made those calls, she tried to call the highway patrol, but had the wrong number. LMFS then called to get law enforcement help. She additionally called BGE airport and Valdosta approach, but neither had seen nor heard from N164GP. The ATM then relieved her of RCIC duties and told her to go get something to eat and drink. She recalled someone calling in with some coordinates for the last known position of N164GP, but she had no idea where the coordinates were or where they had come from. She did not receive confirmation that there had been an accident until after she had already arrived home, and the FLM called to say they had found the wreckage.

When asked how she got the location [coordinates] for SAR (search and rescue) purposes, she stated that she asked the controllers that were on position for it. They performed a "splat T" function, and stated that the last observed location of N164GP before it went into "coast" was 13 miles west of 70J. She did not know how to use Falcon [rapid air traffic replay tool] at all. She also stated that once she heard the coordinates provided by whoever the other source was, she did not look to see where that location actually was, she just passed on the information.

She said she was concerned, from the time the pilot of N164GP had reported the airport in sight while she was still on position, because she did not believe he could have seen the airport from that distance, especially with the weather conditions at the time. Since he had switched to UNICOM before she had the opportunity to instruct him to maintain VFR, he remained tagged up. She went ahead and inserted "HV" in the datatag indicating that it was a VFR flight. She did not continue to monitor the airplane after he had terminated his IFR and switched, but did start watching and listening when she heard the RE-OJTI and RE-DEV controllers talking to him again.

She recalled hearing the low altitude alerts when they alarmed, but said she did not look to see what was generating the alarms. She never thought the pilot of N164GP sounded like he was in distress. She said the pilot seemed confident to her on the air, however, she felt the things he was requesting were just impossible due to the weather; but he seemed adamant about continuing.

With regards to PIREP solicitation and dissemination, she knew that the weather conditions that day required that PIREPs be solicited. When asked why she was not soliciting them on that

day, she had no answer. She said that when working as RCIC it was her responsibility to ensure controllers solicited PIREPs when required, and that she sometimes prompts controllers to solicit them. When asked about the process by which PIREP information is transmitted, she said normally it was just written on a blank strip or piece of paper and passed to ground control/clearance delivery in the tower, who then ensured that it was called into LMFS. She had not seen PIREP forms in the facility. She stated that PIREPs were received from other facilities via the FDIO. When asked, she said it never occurred to her to get a PIREP from the earlier flight she had up near BGE (considering the fact that they have no weather support at 70J and N164GP was attempting to fly into there). She would give the facility a grade of "B" in the area of PIREP solicitation and dissemination.