Docket No. SA-531

Exhibit No. 3-A

NATIONAL TRANSPORTATION SAFETY BOARD

Washington, D.C.

Air Traffic Control Group Chairman's
Factual Report

(16 Pages)

NATIONAL TRANSPORTATION SAFETY BOARD
Office of Aviation Safety
Washington, DC 20594

April 29, 2009

ATC GROUP CHAIRMAN'S FACTUAL REPORT

DCA09MA027

A. AIRCRAFT ACCIDENT

Location: Clarence Center, New York

Date: February 12, 2009 / February 13, 2009 Coordinated Universal Date

Time: 2217 Eastern Standard Time / 0317 Coordinated Universal Time

Aircraft: N200WQ, Colgan Airlines operating as Continental Connection flight 3407 (CJC3407), Bombardier DHC8

B. AIR TRAFFIC CONTROL GROUP

Mr. Scott J. Dunham
National Transportation Safety Board
Washington, D.C.

Mr. James Davis
National Air Traffic Controllers Association
Warrenton, Virginia

Mr. Dan Strawbridge
Federal Aviation Administration
Washington, D.C.

Capt. John Drexler
Air Line Pilots Association
Newark, New Jersey

C. SUMMARY

On February 12, 2009, about 2217 eastern standard time (EST), a Colgan Air Inc., Bombardier Dash 8-Q400, N200WQ, d.b.a. Continental Connection flight 3407, crashed during an instrument approach to runway 23 at the Buffalo-Niagara International Airport (BUF), Buffalo, New York. The crash site was approximately 5 nautical miles northeast of the airport in Clarence Center, New York, and mostly confined to one residential house. The four flight crew and 45 passengers were fatally injured and the aircraft was destroyed by impact forces and post crash fire. There was one ground fatality. Night

visual meteorological conditions prevailed at the time of the accident. The flight was a Code of Federal Regulations (CFR) Part 121 scheduled passenger flight from Liberty International Airport (EWR), Newark, New Jersey to BUF.

D. DETAILS OF THE INVESTIGATION

The air traffic control group met at Buffalo Airport Traffic Control Tower (BUF ATCT) on February 13, 2009. We met with Jeffrey Lynch, Air Traffic Manager; Jeff Rich, Air Traffic Organization Safety (ATO-S); Freddie Valerio, Federal Aviation Administration Eastern Terminal Service Area, and with several other FAA staff members. Mr. Rich and Mr. Valerio were designated as coordinators for the investigation. The group reviewed radio recordings, radar data, and other documentation related to the flight. On February 14, the group returned to complete a tour of the tower and radar approach control facility, completed data collection, and interviewed two of the three controllers on duty. The group then completed the on-scene portion of the investigation and left the facility.

On March 11, the group interviewed the third controller on duty at BUF at the time of the incident via telephone.

1. History of Flight

CJC3407 contacted EWR clearance delivery at 1932. The clearance delivery controller was advising all aircraft of indefinite delays because of severe turbulence at low altitude in the vicinity of the airport, reported by a Boeing 777 and a Boeing 737. After confirming their clearance, the crew was instructed to contact flow control when ready to taxi. CJC3407 contacted the flow control position at 2012, and after a brief discussion the crew was told to monitor ground control for taxi instructions. The EWR ground controller cleared CJC3407 to taxi at 2030. At 2036, the ground controller advised CJC3407 that they were approximately number 16 for departure and instructed the crew to monitor local control. CJC3407 was cleared for takeoff at 2118.

CJC3407 was subsequently handled by New York Terminal Radar Approach Control, New York Center, and Cleveland Center. There were no unusual occurrences, and the flight proceeded routinely. At 2203, CJC3407 contacted Buffalo Approach. The pilot reported leaving 12,000 feet for 11,000, and reported having automatic terminal information service[1] (ATIS) information "Romeo".[2] The BUF East Radar controller instructed the pilot to plan on the ILS approach to runway 23 at Buffalo, and the pilot acknowledged. During the next eight minutes, the controller vectored CJC3407 toward the ILS final approach course, progressively clearing the aircraft to descend to 2,300 feet.

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[1] ATIS is defined in the Pilot/Controller Glossary as "The continuous broadcast of recorded noncontrol information in selected terminal areas. Its purpose is to improve controller effectiveness and to relieve frequency congestion by automating the repetitive transmission of essential but routine information."

[2] Information Romeo was issued at 2054, reporting wind 250 at 15 gusting to 23, visibility 3 miles in light snow and mist, few clouds at 1,100, ceiling 2,100 overcast, temperature 1, dew point -1, altimeter 29.78. Information Sierra was issued at 2154, reporting wind 250 at 15 gusting to 22 knots, visibility 3 miles in light snow and mist. Few clouds at 1,100, ceiling 2,100 broken, 2,700 overcast, temperature 1, dew point -1, altimeter 29.79.

At 2212:44, the controller instructed CJC3407 to fly heading 330. At 2214:09, the controller amended the heading to 310 degrees. At 2215:14, the controller instructed CJC3407 to fly heading 260 to intercept the localizer and to maintain 2,300 feet until established on the localizer. The controller then cleared CJC3407 for the ILS 23 approach. The pilot acknowledged. At 2216:07, the controller instructed the pilot of CJC3407 to contact Buffalo tower on 120.5. The pilot acknowledged.

At 2217:00, the approach controller called the tower controller to ask if something had happened to CJC3407, and instructed the tower controller to attempt to contact the aircraft. During the next minute, both the tower controller and the approach controller attempted to reestablish contact with CJC3407 without success.

A second controller in the approach control overheard the radar controller attempting to reestablish contact with CJC3407, and came to the control position to assist. The radar controller advised him that he believed they had lost an aircraft. The second controller contacted the airport rescue and firefighting service to advise them of the possible accident. The airport fire department responded that they would check, and shortly afterward advised the controllers that there had been an aircraft accident in Clarence Center, New York.

At 2221, the approach controller asked a Delta flight on approach whether they were in icing conditions. The crew responded that they had picked up some ice during the descent, mainly between 6,500 and 3,500 feet. At 2223, a USAirways flight reported rime icing. At 2225, the controller again asked the Delta flight about icing. The crew responded that the aircraft was no longer building up ice, but that the aircraft had about 1/4 to 1/2 inch of ice on it. At 2225, the USAirways crew reported that they had been experiencing rime icing for about 10 minutes, beginning about 20 miles south of the airport. At 2227, as the aircraft was descending through 2,300 feet, the crew reported that they were in instrument conditions, but that the ice was starting to dissipate.

At 2231, CJC3268 (another DHC8 similar to CJC3407) contacted BUF approach en route to BUF. The controller advised the crew of the accident involving their company flight, that four other aircraft had successfully completed the approach after the accident, and that the icing conditions appeared to improve below 2,300 feet. The crew acknowledged. At 2238, the approach controller asked CJC3268 if they had encountered any icing. The crew reported light to moderate mixed icing.

2. Radar Data

Radar data for this accident was obtained from the STARS radar data processing system connected to the ASR-9 sensor located on the Buffalo airport. Figures 1 through 5 are graphic depictions of the aircraft track created from target data extracted from the STARS radar processor.

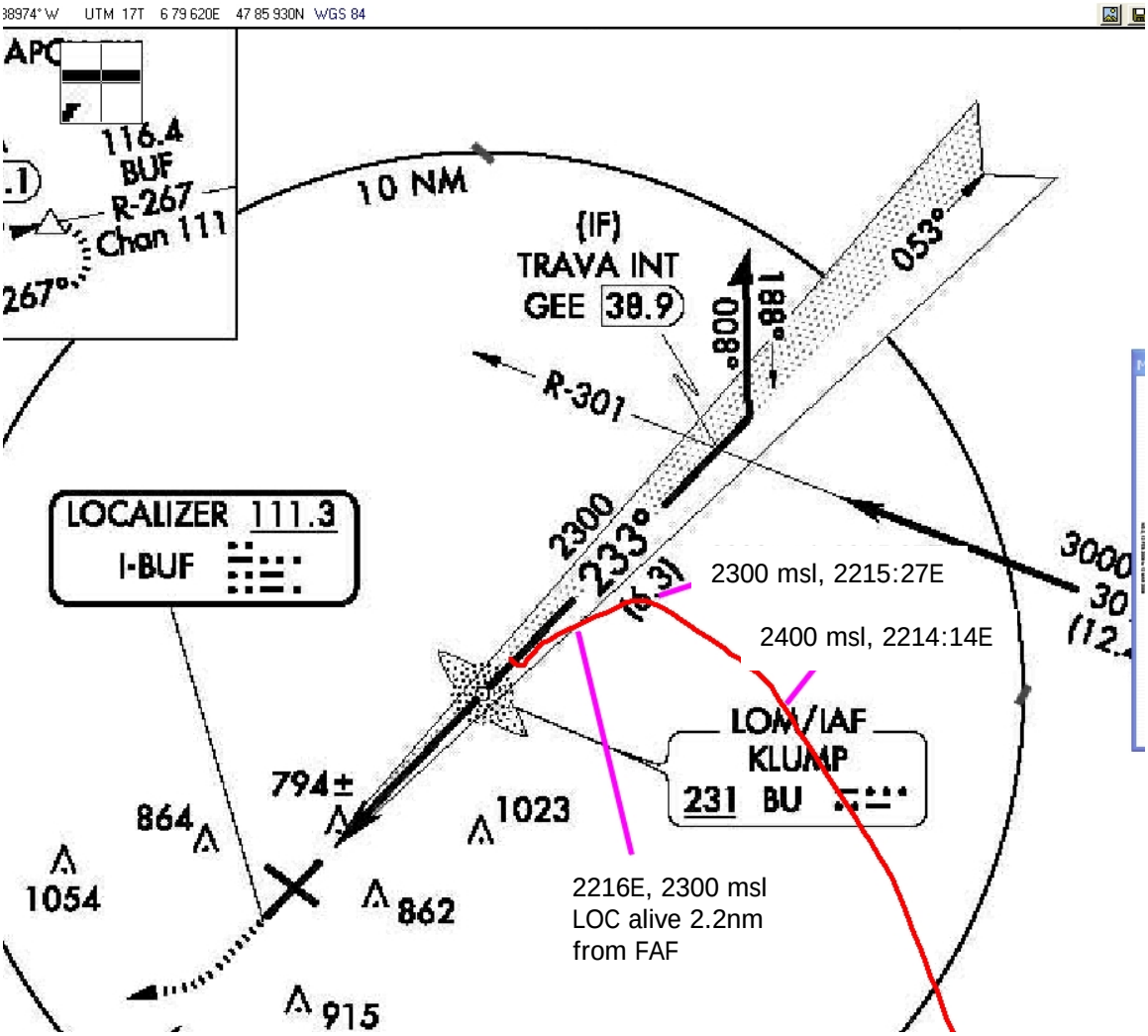

Figure 1 – Annotated ILS intercept, CJC3407

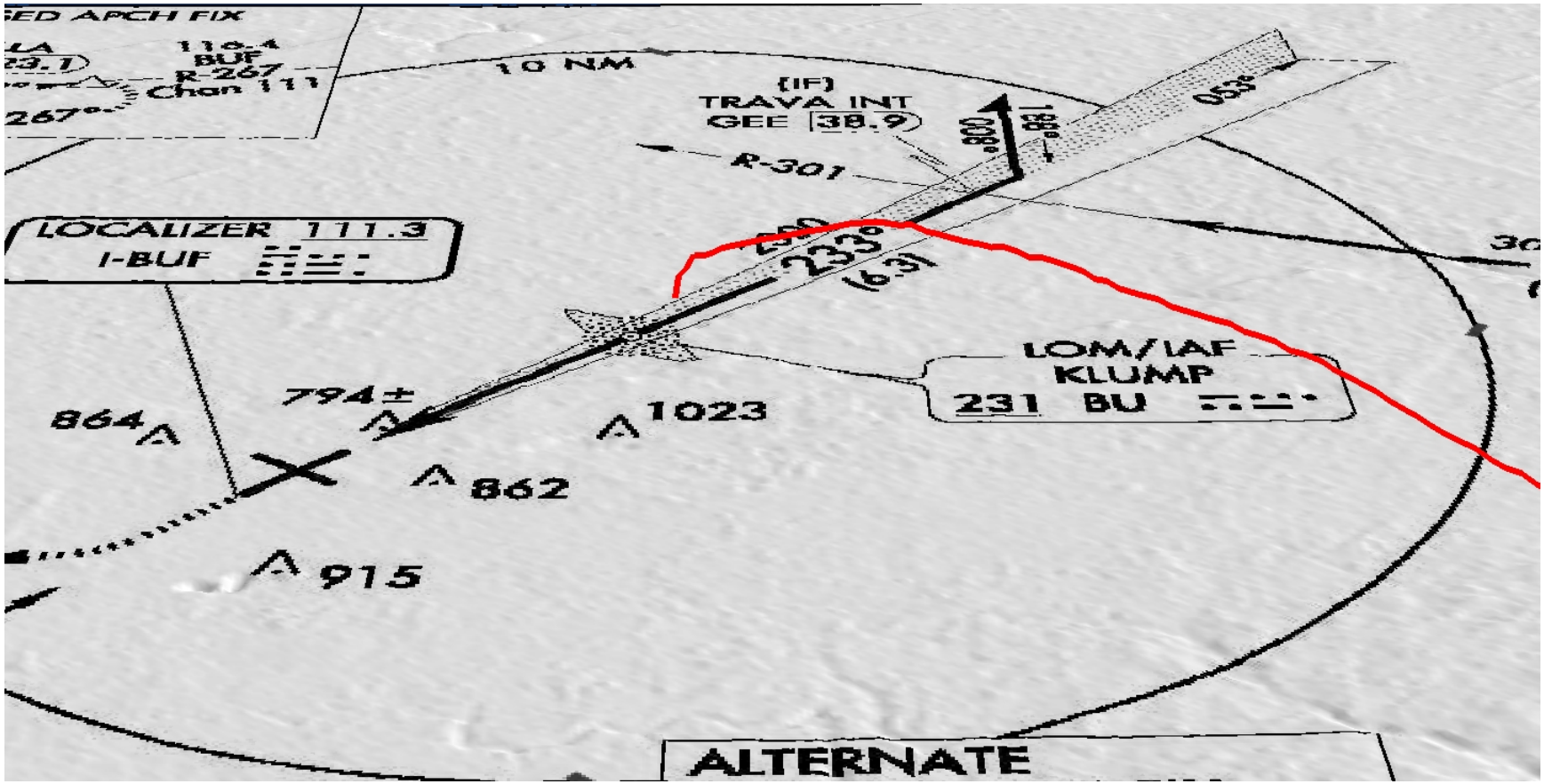

Figure 2 – 3D Profile overview.

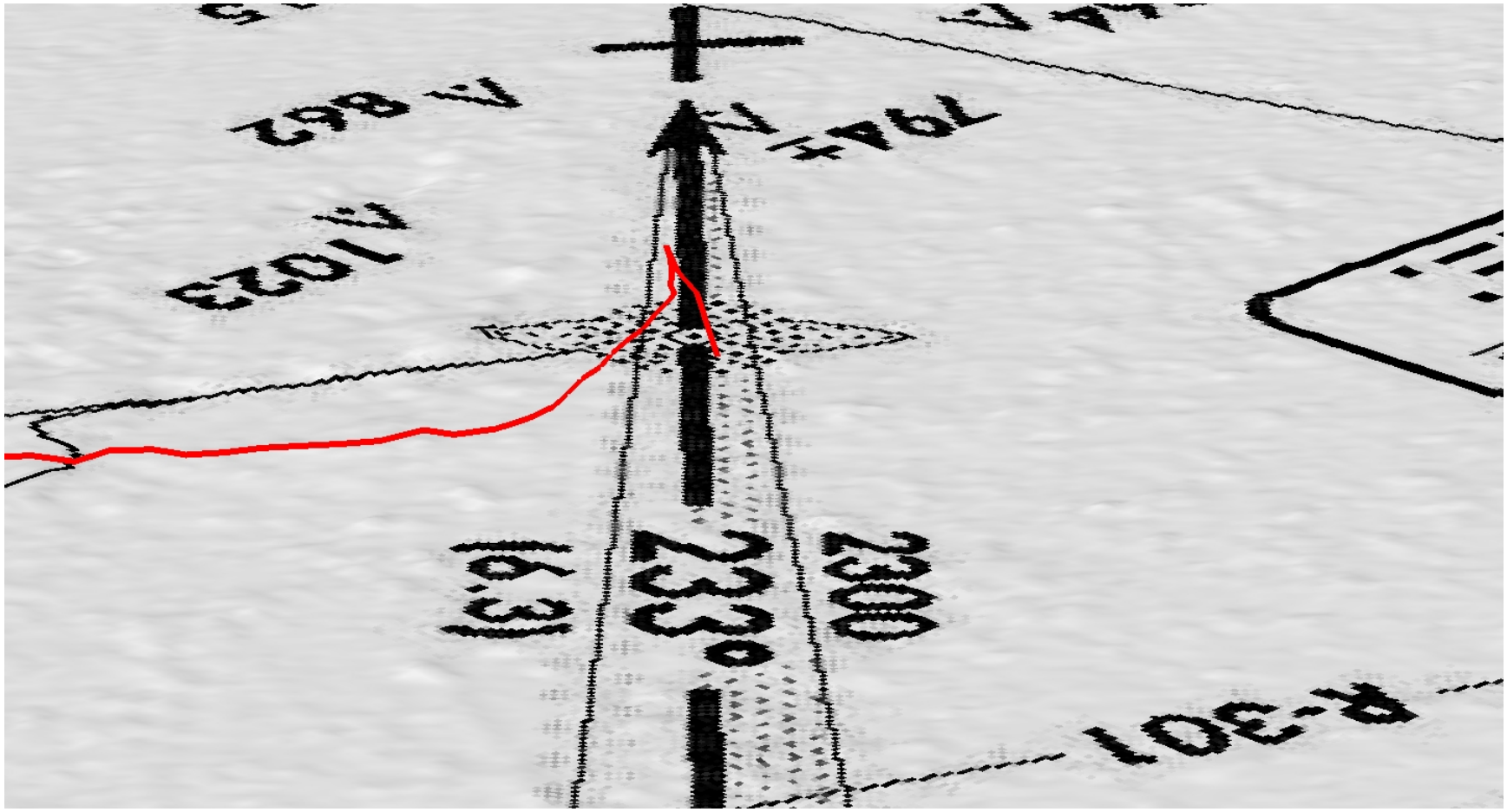

Figure 3 – 3D trail view.

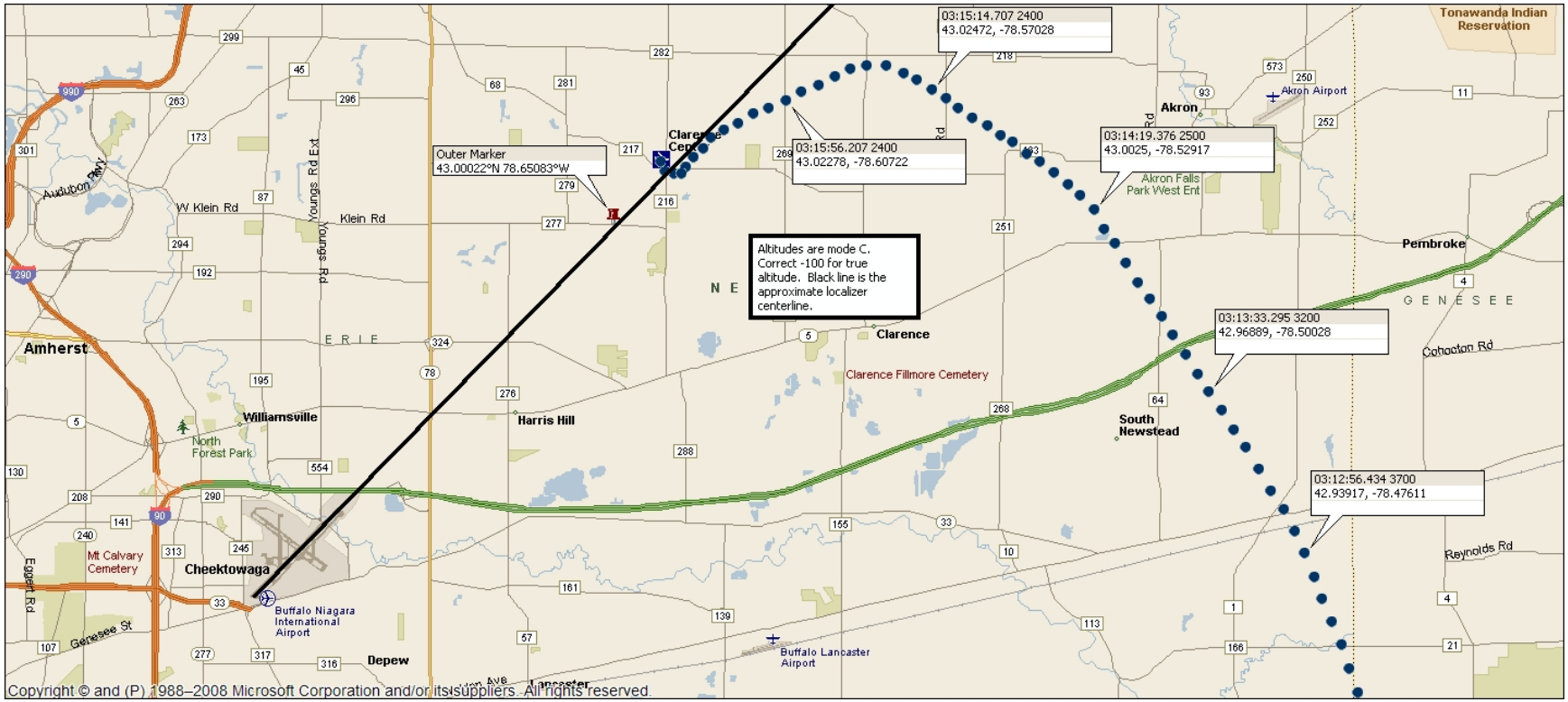

Figure 4 – Track overview. (Times in UTC, 5 hours ahead of local time.)

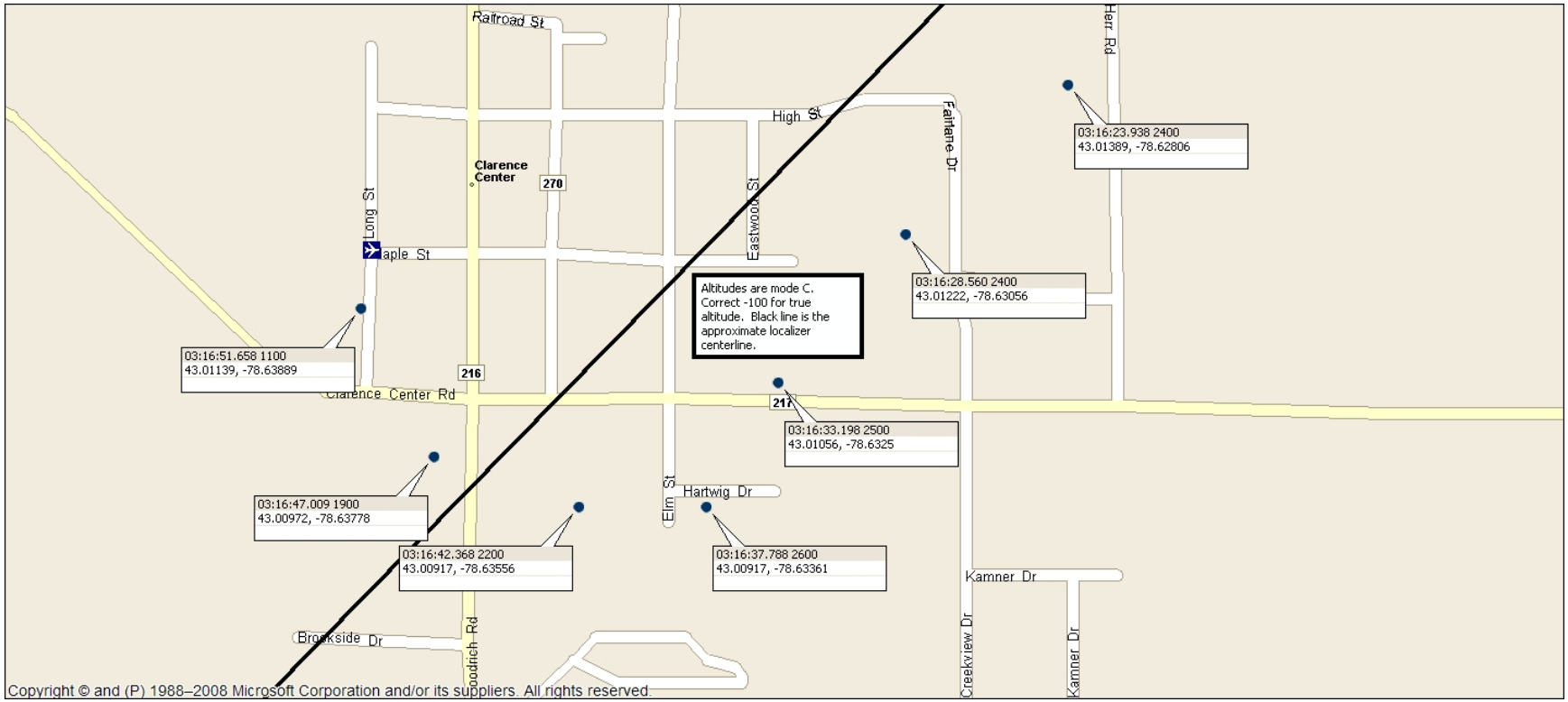

Figure 5 – End of flight and accident site. (Times in UTC, 5 hours ahead of local time.)

3. Personnel Interviews

Lonnie Adamcyzk **BUF East Radar Controller**

Mr. Adamcyzk entered on duty with the FAA in March 1986. He worked at Cleveland Center and Rochester ATCT before coming to Buffalo in September 2003. He completed training at Buffalo on February 25, 2004. He completed refresher training modules on winter operations in September and October 2008. He has a current medical certification which expires April 30, 2009.

On the day of the accident, Mr. Adamcyzk arrived at work at 1620. He was scheduled to work until midnight. He stated that the weather was fairly normal for the winter in Buffalo, with snow showers. There were no unusual equipment or personnel issues affecting his performance.

When Mr. Adamcyzk took over the radar position, he was advised by the previous controller that there were no current pilot reports of icing. Weather at the airport was VFR, which was somewhat improved from the previous ATIS information. Icing conditions were common in the Buffalo area pretty much all winter. As aircraft came into the area, controllers often asked for pilot reports. Mr. Adamcyzk noted that icing conditions over the lake to the west of the airport could be different from conditions over the land to the east, and said that he tried to account for that when he solicited pilot reports. He also tried to validate reports according to the type of aircraft as well, taking into account whether the report was from a 737, a turboprop such as a DHC-8, or a light aircraft; he attempts to update these pilot reports every 20 minutes. His assessment of the information that there were no recent icing reports was that it only meant that there had been no reports, not that there was no icing. His overall assessment was that it was a fairly normal operation taking into account known weather and radar observations. There was no indication of any weather conditions serious enough to affect flight operations. Even though there may have been icing conditions in the area, Mr. Adamcyzk characterized it as a common flight condition around Buffalo in the winter, "routine stuff that pilots fly in here every day."

Asked if he had ever noticed anything different about icing characteristics of DHC-8 aircraft versus any other airline aircraft flying into the airport, Mr. Adamcyzk said that he had not.

Mr. Adamcyzk stated that when CJC3407 approached the airport, his original plan was to sequence the flight behind a Delta aircraft that was also coming into Buffalo. The pilot of the Delta flight advised that he was planning to do an "autoland" (autopilot landing) arrival. Mr. Adamcyzk wasn't sure whether the autoland procedure would result in a slower than normal approach by the Delta aircraft, so he decided to change the plan and put CJC3407 into the sequence ahead of Delta. He began clearing CJC3407 to descend, which was routine handling for the lead aircraft in the sequence. There was a strong wind blowing out of the southwest, so Mr. Adamcyzk issued CJC3407 two vectors toward the localizer as the aircraft approached the airport. He stated that when the winds were strong

he frequently used two smaller turns instead of one large turn when vectoring aircraft to intercept the localizer because it resulted in a smoother arrival. He stated that when turning aircraft off a right downwind arrival for the ILS to runway 23, he would normally use a 140 heading for the base leg. On this evening he was instead using a 160 to 170 heading because of the wind.

When CJC3407 first entered BUF airspace, Mr. Adamcyzk cleared the pilot to proceed direct to TRAVA. He stated that he often used direct routings for initial vectors toward the localizer because he then did not have to account for wind correction when the pilots were using their own navigation. As the aircraft came closer to the localizer, he instructed the pilot to turn to a 330 heading, and then issued a second turn to heading 310. Shortly afterward, he turned CJC3407 to heading 260 to intercept the final approach course, instructed the pilot to maintain 2,300 feet, and cleared the pilot for the ILS approach to runway 23. He monitored the aircraft to ensure that the aircraft correctly intercepted the localizer, and watched its speed to estimate the effect of the wind and the possible effect of the wind on the next aircraft in the sequence. Once he saw that CJC3407 was on the localizer, he instructed the pilot to contact the tower. He continued to monitor the aircraft's progress and shortly afterward saw that the altitude readout in the aircraft data block had changed to "XXX", indicating that the radar system had declared the altitude readout unreliable. He knew from prior experience as an en route controller that this was generally an indication of a very rapid altitude change. There was no minimum safe altitude warning, probably because the altitude information was not being recognized by the computer. The aircraft target disappeared from the radar. Mr. Adamcyzk stated that he was hoping it was a transponder issue. He called the local controller to ask what happened to the Colgan flight. The data block dropped off the display, and Mr. Adamcyzk then noted that he could not see a primary target for the aircraft, either. At that point he knew something bad had happened. The local controller informed him he could not see the aircraft, so Mr. Adamcyzk instructed the local controller to attempt to contact the flight. Mr. Adamcyzk also attempted to reestablish contact with the aircraft. There was a Delta flight on right base for runway 23. Mr. Adamcyzk then asked the pilot of the Delta aircraft to look for CJC3407 off to his right. The pilot responded that he could not see any aircraft, and that there was also no target on the aircraft's TCAS (collision warning system). Mr. Adamcyzk took that as confirmation that CJC3407 was gone.

The second controller in the approach control, Mike Lowry, overheard some of the discussions about CJC3407 and came to the sector to assist. Mr. Adamcyzk then told him to call the fire department. Mr. Adamcyzk contacted the local controller again to ask him to see if a helicopter around the airport might be available and able to help locate CJC3407.

Mr. Adamcyzk stated that he then began trying to figure out what had happened to CJC3407. He began asking other aircraft in the area about icing. Some aircraft reported encountering icing, but the conditions reported did not seem especially serious. He considered the possibility that the icing conditions had become more severe than they had been previously. After the accident, Mr. Adamcyzk planned on putting the other aircraft into holding at 4000’ because of uncertainty about the location of the missing aircraft.

After some consideration of the possible weather conditions, he thought better of it. He contacted the inbound Delta flight and advised the pilot that he would bring the aircraft in on the approach. However, he cautioned the pilot to be aware of any ILS issues or inaccuracies and advise if he encountered anything abnormal. Mr. Adamcyzk also considered the possibility that there had been something wrong with the ILS equipment, so he turned to check the monitor panel in the approach control, located about 10 feet away from the control position he was working. It appeared all normal and there were no alarms.

Mr. Adamcyzk stated that he found out an accident had definitely occurred when Mike Lowry was advised by the airport fire department of the downed aircraft. Mr. Lowry came to the sector and asked Mr. Adamcyzk if he needed to be relieved from the position. Mr. Adamcyzk considered his options and decided that he preferred to continue working on the radar rather than to participate in the accident notification process. He would have had to made the notification phone calls because there were no other personnel available. He also thought it would be operationally better for him to continue on the radar rather than brief a new controller.

Mr. Adamcyzk was uncertain whether he was actually on the facility log as the controller in charge, but stated that he would eventually have become the controller in charge because of his schedule. The controller assigned to the 1600 shift always became the CIC at some point. Mr. Adamcyzk was relieved from the position when the midnight shift controller arrived, probably around 2230. By then the facility manager and the supervisors were beginning to arrive. Mr. Adamcyzk then filled out a personnel statement and helped with collection of data about the accident. He was trying to remain occupied and to help out rather than taking a break and possibly having to watch the accident on television. Mr. Adamcyzk reiterated that he considered taking the relief offer when it was offered, but decided on his own that he would rather continue working. He did not expect his decision to have any effect on his performance and he was content to continue on the radar. He knew that the midnight shift controller typically came in early, and expected to be relieved fairly soon.

Mr. Adamcyzk characterized the evening traffic around the time of the accident as fairly typical. It was common during that part of the night to encounter a minor surge in traffic, with both overflights and arrivals.

Mr. Adamcyzk then noted that controllers at Buffalo routinely received refresher training on winter weather and icing. Asked how the facility handles weather advisories such as AIRMETs and SIGMETs, Mr. Adamcyzk stated that he reviewed each one to determine whether it needed to be broadcast, mainly by assessing whether it affected the area around Buffalo. He also considered the routes of flight of departing aircraft and if he believed that a particular weather advisory would affect that aircraft, he would ensure that the pilot had received it or issue it again himself. Mr. Adamcyzk stated that his normal practice when he read a weather advisory was to put his initials on the strip along with the time, and then file the strip at the sector. However he noted that this was not a required facility practice and that other controllers did not necessarily handle the weather

advisories the same way. Buffalo still used pilot report forms, but it was Mr. Adamcyzk's understanding that the FAA no longer published these forms. When pilot reports were received they were forwarded to the flight service station.

Larry Pogorzala **BUF ATCT Local Controller**

Mr. Pogorzala entered on duty with the FAA in August 1982. He was initially assigned to the tower in Burlington, Vermont, later transferring to Baltimore tower, Rochester tower, and then Buffalo tower in September 2003. He was fully certified at Buffalo on February 25, 2004. Mr. Pogorzala had a current medical certificate that expired October 31, 2009. During his career, Mr. Pogorzala had acquired staff experience as an airspace and procedures specialist, a quality assurance specialist, and training specialist.

On the day of the accident, Mr. Pogorzala was working a 1600 shift as the local controller in the tower. There was a second controller assigned to the shift, but he went home sick. There were no other unusual issues affecting operations, and traffic around the time of the accident was normal for that point in the evening. The weather earlier in the shift, around 1800 or 1900, was definitely worse than it was around the time of the accident. Mr. Pogorzala was alone in the tower after 2200. The midnight shift controller typically came in between 2230 and 2315, because the shift had a flexible starting time.

The airport vehicles were operating on the runways trying to keep them clear of contamination. Mr. Pogorzala stated the normal practice was to allow the vehicles to operate on the runways until an aircraft approached the airport, then instructed the vehicles to clear the runway while the aircraft landed. Once the aircraft was down and clear of the runway, he could then authorize the airport vehicles to resume operations.

When Mr. Pogorzala took over the local control position, CJC3407 was approximately 20 miles southeast of the airport. During the next few minutes, Mr. Pogorzala recalled handling a FedEx aircraft as well as a group of sweeper vehicles that had requested access to the runways. Things then started getting fairly quiet. The approach controller called the tower to ask if Mr. Pogorzala was in communication with CJC3407. Mr. Pogorzala stated that he looked at the radar display and looked out the window but did not see the aircraft. The phone call brought to mind an incident that occurred about a week previously when a controller was working an aircraft whose tag dropped off the radar display. Normally when the tag dropped, there was still a primary target visible on the radar. In the situation Mr. Pogorzala recalled, there was no primary target displayed. He remembered that the supervisor had immediately began trying to locate the aircraft as he was very concerned that there was no target. After a few seconds the aircraft reappeared and was seen to be safe. Having seen that scenario recently, Mr. Pogorzala stated that he thought perhaps the same thing had occurred with CJC3407. He looked at the arrival list on the tower radar display, but the aircraft was not in the list, either. At that time the approach controller called back to check on the aircraft, and Mr. Pogorzala asked him to provide the aircraft's call sign. The approach controller did so, and Mr. Pogorzala made several calls to the aircraft without success. The approach controller discussed the possibility of getting a helicopter from the airport to go out and assist in locating the

aircraft. Mr. Pogorzala was also trying to decide what to do to locate the aircraft, and went over to the tower IDS system to begin looking for phone numbers of organizations that could assist. At that point he heard Mike Lowry, downstairs in the TRACON, using the crash phone to communicate with the airport fire department. When conversations occurred on the crash phone, they were audible in both the tower cab and the approach control. A few seconds later Mr. Pogorzala stated that he saw the airport fire vehicles coming out of the station. He called one of the fire trucks on the radio and advised the firemen of a possible downed aircraft near the airport. The firemen responded that they would check. Shortly afterward the firemen contacted the tower to report a confirmed downed aircraft northeast of the airport.

At that point Mr. Lowry called the tower cab and stated that he could not locate the air traffic manager. About then the mid-shift controller came in, so Mr. Pogorzala briefed him on the situation and the operations in progress, and allowed him to take over the position. He then began assisting with the phone calls and other notifications associated with the accident. He recalled talking to both the flight standards office and the local sheriff. He also contacted the air traffic manager's wife at home and she was able to provide the ATM's cell phone number. He called the cell phone number and informed the ATM of the accident. There were several other calls coming into the tower from the Transportation Authority, Continental Airlines and others. It was very busy for a while, but eventually things started to settle down and the initial activity abated, Mr. Pogorzala sat with the two approach controllers in the break room. They wrote personnel statements and waited for a decision on whether drug testing would be required. Eventually they were informed that drug testing would not be required, and were released to go home around 0300.

Asked about the use of flight strips at Buffalo, Mr. Pogorzala stated that strips were not normally used for arrivals and were not printed in the tower. For control information related to an arriving aircraft, Mr. Pogorzala typically coordinated directly with the TRACON and made notes on a pad as necessary. When he configured the radar equipment in the tower cab, he normally left one radar display on maximum range to cover all the airspace and to watch for arriving aircraft. He stated that this was helpful in planning traffic and especially in managing airport vehicles during runway clearing operations. He ran a second scope zoomed in closer to the airport to get more resolution. He stated that the tower had a specialized weather display available as well that was driven by the weather channel of the ASR-9. He sometimes used the weather display to give pilots additional precipitation information. There were no comments from any pilots about weather such as turbulence or icing around the time of the accident

Mr. Pogorzala stated that he handled weather advisories by disseminating them if they cover any part of the area within 150 miles of Buffalo. He also watched for specific aircraft that may be affected by a particular advisory and ensured that the pilots of those aircraft were aware of the information. When the tower received pilot reports about conditions on the approach or elsewhere in the vicinity of the airport, the reports were passed downstairs to the radar approach control for immediate use. When approach controllers received a weather advisory, they typically analyzed the content, read the

advisory if necessary, and filed the strips. Weather advisory strips were not typically retained at the position after being read.

Michael Lowry **East/West Approach Controller and CIC**

Mr. Lowry entered on duty with the FAA in January 1983, arriving at Buffalo in April 1983. In April 1989, he transferred to Washington National tower, where he remained until October 1991. He returned to Buffalo in October 1991, and has been employed at Buffalo tower since that date.

On the day of the accident, Mr. Lowry was working a 1500 to 2300 shift, but came to work at about 1430. At Buffalo it is normal for controllers to work the entire shift in either the tower or the radar room, and on that day Mr. Lowry was assigned to the radar room all evening. He stated that during the shift, weather was coming and going, and for some time the airport was VFR with visual approaches in progress. However, after 1800 the weather deteriorated. It was a fairly routine evening for the most part. Traffic consisted mostly of air carriers and other IFR operations because of the weather. From 2100 until about 2200, Mr. Lowry was working the east and west radar positions combined. At about 2200, he was relieved from position by Mr. Adamcyzk. Mr. Lowry then switched over to the approach data position, and was working approach data when the accident occurred. He became aware that something had gone wrong when he heard Mr. Adamcyzk talking to the tower controller. The Colgan flight had been cleared for the ILS approach and issued a frequency change to the tower. The pilot acknowledged but did not check in.

Shortly after the frequency change, Mr. Lowry heard Mr. Adamcyzk tell the tower to "…check on Colgan" because the aircraft had dropped off the scope. That discussion is what got Mr. Lowry's attention. He looked at the West scope to evaluate the situation and see what other traffic was in the area. There were three or four inbounds and an overflight or two. Based on what he had seen and heard, Mr. Adamcyzk was fairly certain about what had happened. There was no primary target, and he had lost communication with Colgan Airways. About five minutes after the loss of contact with the aircraft, Mr. Lowry called the airport fire department and advised them that an aircraft had disappeared on final approach. The airport fire department coordinates all off-airport incidents. About 10 minutes after the loss of contact with the aircraft, the airport fire department contacted the tower and confirmed that there was an aircraft down. Mr. Lowry evaluated the radar situation and offered to relieve Mr. Adamcyzk from the approach position. Mr. Adamcyzk declined, stating that he wanted to continue to work the position.

After that Mr. Lowry tried to call Jeff Lynch, the Air Traffic Manager, but was unable to locate him. Because he was the controller in charge, Mr. Lowry started doing the accident and incident checklist, which required him to call Cleveland Center, the regional operations center, and local authorities to notify them of the accident. Sometime later, front-line managers Costello and Friedenberg reported to the tower to help with the accident. There were lots of phone calls and other activity going on. At about 2230, the midnight shift controller came in and relieved Mr. Adamcyzk from the approach position.

Sometime between 2320 and 0000, Mr. Lowry was relieved from the CIC position and completed a controller statement. Front-line manager Costello began handling all the calls. The three controllers on duty in the approach control and the tower when the accident occurred were held over pending a decision about drug testing. Eventually, the management decided the drug testing would not be required and the three controllers were released to go home.

A review of the recorded transmissions during the period that Mr. Lowry was working the approach control radar position showed that when he took over the position, he was briefed about an icing report supplied by an E145 aircraft that had encountered light icing between 4000 and 5000 feet. During the period that he was working the position, there were no further discussions about icing with any of the pilots, but when Mr. Lowry was relieved from the position he advised Mr. Adamcyzk that there was "negative icing." Asked how he made that assessment, Mr. Lowry stated that during the period he worked about 20 aircraft and no one mentioned any icing. This led him to conclude that icing was not a significant factor for flight during that time. Mr. Lowry stated that when pilots did supply information about icing, controllers obtained a description of intensity, location, types of icing, and altitudes affected, and then passed along the pilot report to flight service and other aircraft. Mr. Lowry stated that he was aware that FAA order 7110.65 requires controllers to obtain pilot reports under certain conditions. Among those conditions are known icing, thunderstorms, turbulence, and ceilings or visibilities below 5000 feet and 5 miles. Under those conditions, controllers were expected to obtain a pilot reported least once every hour. He did not solicit any pilot reports during the time he was on position. Asked why not, Mr. Lowry stated that light icing is practically routine for the Buffalo area in the winter, and the lack of reports generally indicates that the icing present is not significant or the pilots would be saying something about it. Regarding the earlier pilot report from the E145 crew, Mr. Lowry was not sure if it had been solicited by the previous controller or supplied by the pilot without request.

Mr. Lowry noted that Buffalo was subject to rapidly changing weather conditions, whether those conditions involved icing, thunderstorms, wind shear or other phenomena. Sometimes icing in the area changed from moderate to severe and then to no icing in a very short period. The facility expected controllers to comply with the 7110.65 guidelines and to keep pilots updated on changing conditions.

Asked about his decision to leave Mr. Adamcyzk on the approach control position after the accident occurred, Mr. Lowry stated that under the circumstances he would probably do it again. Mr. Adamcyzk was composed, doing a good job, was trying to do the right thing with the traffic, and had all the support he needed. Mr. Adamcyzk felt comfortable staying at the position.

Regarding the reported phenomena of aircraft pitching up during glideslope intercept from the north side of the airport, Mr. Lowry stated that as far as he knew the problem only occurred on the north side of the localizer and not when aircraft intercept from the south.

Scott Dunham
ATC Investigator