



National Transportation Safety Board

Washington, D.C. 20594
Safety Recommendation

Date: November 15, 1995

**In reply refer to: A-95-98 through -100
and A-95-116 through -119**

Honorable David R. Hinson
Administrator
Federal Aviation Administration
Washington, D.C. 20591

On December 13, 1994, at 1834, a Flagship Airlines Jetstream 3201, doing business as (dba) American Eagle (AMR) flight 3379, crashed about 4 nautical miles southwest of the runway 5L threshold during an instrument landing system approach to the Raleigh-Durham International Airport (RDU). The flight was a regularly scheduled passenger flight under 14 Code of Federal Regulations (CFR), Part 135.¹ Thirteen passengers and the two crewmembers were fatally injured, and the other five passengers survived. The airplane was destroyed by impact and fire. The weather at the time of the accident was ceiling 500 feet, visibility 2 miles, light rain and fog, temperature 38° F, and dew point 36° F.

The National Transportation Safety Board has determined that the probable causes of this accident were: 1) the captain's improper assumption that an engine had failed, and 2) the captain's subsequent failure to follow approved procedures for engine failure, single-engine approach and go-around, and stall recovery. Contributing to the cause of the accident was the failure of AMR Eagle/Flagship management to identify, document, monitor, and remedy deficiencies in pilot performance and training.

¹For more detailed information, read Aircraft Accident Report-- "Uncontrolled Collision With Terrain, Flagship Airlines, Inc., dba American Eagle Flight 3379, BAe Jetstream 3201, N918AE, Morrisville, North Carolina, December 13, 1994" (NTSB/AAR-95/07)

To reconstruct the approach in this accident, Safety Board investigators correlated data from the flight data recorder, cockpit voice recorder (CVR), and the RDU radar plot for the last minute of flight. There was a change in engine noise similar to an increase in engine revolutions per minute (RPM) at 1833:28.7, seconds after the captain requested "speeds high." This was followed immediately by a call for "gear down and flaps 20." Flight 3379 crossed slightly right of BARRT, the final approach fix, while descending through 2,100 feet and slowing below 160 knots. At 1833:33.3, the captain asked, "Why's that ignition light on? We just had a flameout?" For the next few seconds, the crew discussed the engine anomaly as the airplane heading drifted to the left at approximately $2/3$ of a degree per second and eventually crossed the localizer centerline at 1833:45.

For the next several seconds, the airplane remained relatively level at approximately 1,800 feet, as the airspeed decreased from 140 knots to 122 knots, when the captain decided, "Let's go missed approach." In less than 2 seconds, at 1834:05.3, two momentary stall warnings occurred as the captain called, "Set max power," and the left turn rate increased. The first officer called "Lower the nose, lower the nose, lower the nose," but the airplane remained at around 1,800 feet, and the airspeed continued to decay to approximately 119 knots as the left turn rate increased to about 5° per second.

At 1834:09.4, a stall warning horn started again, and was followed at 1834:09.6 by the dual stall warning horns. At this time, the airplane was still at 1,775 feet, and the airspeed had slowed to 111 knots. The first officer inquired, "You got it?," and the captain responded, "Yeah." The airspeed decreased to 103 knots at 1834:12, and the first officer said "Lower the nose." At 1834:13.2, the first officer said, "It's the wrong, wrong foot, wrong engine." About this time, the rate of descent increased rapidly to more than 10,000 feet per minute. The rate of turn increased to about 14° per second at 1834:16, as the airspeed increased rapidly. There were several significant normal accelerations during this period. The airplane finally stabilized the last few seconds before impact at an airspeed of about 170 knots, a normal acceleration of 2.5 G absolute, and a heading of 290° .

Based on the evidence uncovered in this accident, the Safety Board believes that the captain failed to follow established procedures for engine failure identification, single engine approach, single engine go-around, and stall recovery. Specifically, he associated the illumination of the left engine "IGN" light with an engine failure. However, there was no evidence of such a failure. The CVR sound

spectrum analysis and the examination of the engines and propellers revealed that both engines were operating until impact.

The Safety Board has concluded that the left engine IGN light illuminated as a result of a momentary negative torque condition when the propeller speed levers were advanced to 100 percent and the power levers were at flight idle. The Safety Board believes that AMR Eagle training did not adequately address the recognition of engine failure at low power, the aerodynamic effects of asymmetric thrust from a "windmilling" propeller, and the effect of high thrust on the other engine.

The Safety Board participated in the investigation of an accident involving an engine anomaly by the flightcrew of a Saab 340B, Schiphol Airport, Amsterdam, the Netherlands, on April 4, 1994. That investigation is being conducted under the jurisdiction of the Netherlands Aviation Safety Board, and the final report has not yet been released; however, certain similarities between the two accidents do exist. The flightcrew of the Saab observed the right engine low oil pressure warning light, without any confirming evidence of an actual malfunction. The captain elected to return and land at Schiphol, the main maintenance base. The flightcrew reduced the power to flight idle, in accordance with the appropriate checklist. They also discussed the single engine procedures. There was no further guidance, either in the manuals or training, regarding the use of flight idle during the approach.

Although the captain was experienced in the Saab, he was relatively inexperienced in total time. He was trained in the simulator, and had not participated in engine-out training in the airplane. Prior to the certification of the simulator, when engine-out training was conducted in the airplane, the engine failure was simulated by reducing power on the "dead engine" to 15 percent thrust. This power was required to establish a zero thrust condition and offset the drag of the windmilling propeller. On April 26, 1994, the Netherlands Aviation Safety Board issued a warning, endorsed by the Rijks Luchtvaart Dienst (RLD, the certificating agency of the Netherlands), in part, as follows:

WARNING

Pilots should realize that the propeller of an engine in (flight) idle may produce considerably more drag than the propeller of an engine which has been shut down and feathered.

If for any reason it has been decided to fly the approach with one engine at idle power and the propeller not feathered:

1. The affected engine should be set at a power - or torque setting, at least sufficient to overcome any extra drag (ref. zero-drag setting for simulated single-engine training).
2. The decision to keep the engine at a setting around zero-drag implies that a one engine out approach should be made. This should be realized during the approach preparation. The preparation briefing should at least include the speeds and flap settings to be used according to the one engine inoperative approach, landing, and go-around procedures.

In May 1995, the Federal Aviation Administration (FAA) circulated draft Advisory Circular (AC) 39.XX, "Continued Airworthiness Assessments of Turbine Engines, Propellers, and APUs," for public comment. It is expected to be issued in the spring of 1996. Appendix 2 of the AC provides a listing of air carrier accidents and incidents that involved propulsion system safety hazards. This document defines a "propulsion system plus crew" event as one that initiated from a single propulsion system malfunction that should not have caused a problem, compounded by inappropriate crew response. The FAA reported that 32 of these events occurred between 1982 and 1991, with consequences ranging from severe (fatal accidents and hull losses) to serious (such as an inability to climb more than 1,000 feet above terrain elevation).

Of the 32 propulsion system plus crew events, 18 (56 percent) involved turboprop aircraft. The following examples, as cited in the FAA AC (appendix 2, p. 19), are illustrative of the turboprop-related events:

Lost one engine and crew inadvertently feathered other engine -- forced landing.

On descent, crew shut down right-hand engine but inadvertently shut down left-hand engine also, aircraft struck electrical lines -- fatal.

Crew shut down left-hand engine for fuel leak. Aircraft stalled 1 km from runway and crashed, fatal.

None of the cited events exactly match the accident sequence of American Eagle flight 3379. However, in the more general sense, each flightcrew's aggravation of a benign engine condition demonstrated that the performance of the flight 3379 flightcrew was not an isolated event. The Safety Board believes that the repetitive pattern in propulsion system plus crew events, of which this accident is a part, warrants further corrective action at an industry-wide level.

Circumstances of this accident included the flightcrew's confusion about engine operating status and their inadequate response to a perceived engine failure in a reduced power condition. Therefore, the Safety Board believes that the FAA should publish advisory material that encourages air carriers to train flightcrews in the identification of and proper response to engine failures that occur in reduced power conditions, and in other situations that are similarly less clear than the traditional engine failure at takeoff decision speed.

With regard to FAA air carrier oversight, the investigation revealed that on matters of compliance, the principal FAA inspectors dealt indirectly with AMR Eagle through the FAA focal point coordinator (FPC). The FPC, a full-time specialist, was dedicated to facilitating interaction between the individual inspectors and any single AMR Eagle entity, or the entire organization. This individual had no oversight responsibility but was to facilitate interaction between the principal inspectors of the four carriers and the AMR Eagle management. His duties were administrative in nature, consisting of gathering and distributing information to all appropriate personnel.

The evidence showed that the principal inspectors did not interact with the critical AMR Eagle decisionmakers, who were, in effect, directing the operations of the four carriers. Rather, the FPC, served as the person interacting with AMR Eagle. Additionally, the nature of this interaction was primarily limited to the exchange of correspondence. As a result, the FPC insulated both entities from direct personal involvement. By contrast, in traditional oversight activity, FAA inspectors are in daily contact with key decisionmakers. Effective oversight depends on both a minimum of individual surveillance and an interpersonal relationship between the inspector and the operator's critical decisionmakers. This relationship enables the inspector to gain an understanding of the corporate culture, as well as the reasons for corporate actions. In addition, an ongoing relationship between the principal inspector and the operator's decisionmakers enables the inspector to obtain the carrier's commitment to the highest standards of safety. It is highly unlikely that an inspector could obtain such a commitment from his

assigned carrier solely through correspondence. Therefore, the Safety Board believes that the FAA should review the organizational structure of its surveillance of AMR Eagle and its carriers with particular emphasis on the positions and responsibilities of the FPC and principal inspectors, as they relate to the respective carriers.

In another area, the Safety Board concluded that the FAA did not provide adequate guidance for, or ensure the proper installation of, the flight profile advisory (FPA)-80 as a substitute for a ground proximity warning system (GPWS) on Flagship's fleet. The system, as installed on the Flagship fleet, did not meet the requirements of 14 CFR 135.153. The FPA-80 did not have a visual means of warning the pilot of excessive closure rates with terrain or deviations from the glideslope. In addition, the provisions identified in the FPA-80 Interconnect Diagram that were required for approval were neither incorporated into the systems, as installed on the Flagship fleet, nor were they mentioned in the 1993 correspondence seeking continuing approval of the FPA-80 as a substitute for a GPWS.

The Safety Board does not believe that the absence of a GPWS or the improper installation of the FPA-80 system contributed to the cause of this accident. However, the installation of a GPWS, or an approved alternate system, is essential to safe operation in the air carrier industry today. The Safety Board is concerned that other operators of the J-3201 and similar aircraft may be operating without the protection of a GPWS or its equivalent. Therefore, the Safety Board believes that the FAA should ensure that all airplanes that use the FPA-80 system, in lieu of a GPWS, have installations that comply with Federal regulations.

The investigation revealed that AMR Eagle's application process required prospective employees to complete employment history forms, and to sign civil releases giving AMR Eagle permission to contact previous or present employers. Such an employment practice is not uncommon in the industry, and is intended to check past job performance as a means to predict future performance. Contacting former employers has been shown to be one of the best methods for evaluating prospective employees. The accident captain had signed a release permitting his previous employer to respond to AMR Eagle's inquiries, but a request was apparently not sent by AMR.

By not following the intent of its own hiring procedures, that were established to gather information on an applicant's background, AMR Eagle precluded the

possibility that it could learn that the pilot possessed questionable aviation abilities. If Flagship had asked for, and Comair had provided, the captain's performance history while at their company, it is likely that the deficiencies in the captain's skills would have been specifically addressed prior to his being offered employment. This might have resulted in a decision not to hire him. But, even if AMR Eagle had decided to make an offer of employment, a complete employment history, in the possession of his immediate supervisor, should have made the subsequent complaints regarding his abilities far more meaningful.

Three times previously the Safety Board has recommended that air carriers be required to conduct substantive background checks of prospective airmen/employees before they are hired.² Each time the FAA has essentially rejected the recommendations, and the Safety Board has classified all three as "Closed--Unacceptable Action."

The first recommendation was issued following a DC-9 takeoff accident at Denver, Colorado. The investigation revealed that the first officer had been dismissed by his previous employer because of his unsuccessful performance after 30 hours of simulator training. This information was not obtained in the background check performed for the airline by a contract security company. On November 3, 1988, the Safety Board issued the following recommendation to the FAA:

A-88-141

Require commercial operators to conduct substantive background checks of pilot applicants which include verification of personal flight records and examination of training, performance, and disciplinary records of previous employers and Federal Aviation Administration safety and enforcement records.

The FAA indicated that although it agreed with the intent of the recommendation, "...it does not believe that any benefits derived from such regulatory change would outweigh the costs of promulgating and enforcing the regulatory change."

²Safety Recommendations A-88-141, issued as a result of the Continental Airlines, Inc., accident at Denver, Colorado, November 15, 1987, NTSB/AAR-88/09; A-90-141, issued as a result of the Aloha IslandAir, Inc., accident on Molokai, Hawaii, October 28, 1989, NTSB/AAR-90/05; A-93-14, issued as a result of the Tomy International, Inc., d/b/a Scenic Air Tours accident on Maui, Hawaii, April 22, 1992, NTSB/AAR-93/01.

The second recommendation was issued as a result of a commuter accident at Molokai, Hawaii. This investigation revealed that Aloha IslandAir did not contact the captain's previous employers, and the FAA enforcement and accident records were not checked. The two most recent employers reported that they had already given unfavorable references to other operators, who did inquire about the accident captain. As a result of that accident and the FAA response, Safety Recommendation A-88-141 was classified "Closed--Unacceptable Action/Superseded" on September 25, 1990, by Safety Recommendation A-90-141. Safety Recommendation A-90-141 was identical to A-88-141 except that it added the National Driver Register as a source of background information to be checked. The FAA indicated in its response, dated February 8, 1991, that regulatory action to require background checks would be no more effective than voluntary compliance. In this response, the FAA did note that it had issued Air Carrier Operations Bulletin 8-92-2, "Certificated Airman Preemployment Safety Verification," encouraging airlines to use FAA data bases to verify the validity of an applicant's certificate and safety history. Because the FAA again failed to take the recommended regulatory action, the Safety Board classified Safety Recommendation A-90-141 "Closed--Unacceptable Action" on October 20, 1992.

Although the FAA rejected the recommendation, Aloha IslandAir did not. As a result of a newly implemented preemployment screening procedure, Aloha IslandAir rejected a captain, who misrepresented his employment record. That captain subsequently was hired by Scenic Air Tours, which did not check his background and he was involved in the accident that prompted a third recommendation.

The third recommendation was issued following the Scenic Airlines sightseeing on-demand air taxi accident on Mount Haleakala, Maui, Hawaii. This investigation revealed that the captain had falsified his employment application, and the company failed to conduct a substantive background check to verify his aeronautical experience. On February 19, 1993, the Safety Board issued Safety Recommendation A-93-14 to the FAA, as follows:

A-93-14

Require commercial operators to conduct substantive background checks of pilot applicants, which include verification of personal flight records and examination of training, performance, and disciplinary and other records of previous

employers, the Federal Aviation Administration safety and enforcement records, and the National Driver Register.

Similarly, the FAA disagreed with the third recommendation, contending that it was the responsibility of the airlines to verify the validity of a pilot's certificate. Once again, failure of the FAA to take regulatory action resulted in the Safety Board classifying Safety Recommendation A-93-14 "Closed--Unacceptable Action" on February 22, 1994.

As part of its Safety Study, Commuter Airline Safety, NTSB/SS-94/02, the Safety Board reported:

The Safety Board obtained information on the types of preemployment background checks conducted by air carriers that participated in the commuter airline survey. Eleven of 20 airlines (55 percent) indicated that they routinely check the Department of Motor Vehicle records of pilot applicants, 14 of 20 airlines (70 percent) request a check of pilot applicants' accident/incident history from the FAA, and 9 of 19 airlines (47 percent) check for past alcohol-involved motor vehicle violations. Sixteen of 20 airlines (80 percent) request and verify the professional references provided by applicants; however, officials at many airlines reported that, with the exception of employment dates, past employers provide little or no information on applicants because of fears of legal action. Of the 21 commuter airlines that participated in the survey, 7 (33 percent) routinely include all of the above checks in their preemployment screening of pilot applicants.

Comair's stated policy--the nondisclosure of employee performance information--illustrates the common perception that the release of such information (especially unfavorable information) may lead to civil liability. The commuter study, and information from the Air Transport Association, confirms that Comair's position is typical within the industry.

The Safety Board notes that air carriers are required to conduct security checks of pilot applicants prior to employment because they have unescorted access to security areas. The checks must include references and employment history verification for the preceding years. They also conduct preemployment

screens for alcohol and drug abuse. However, there is no requirement to verify flight experience, determine an applicant's safety/enforcement history, pilot training and performance at his previous employers, or any criminal and driver history.

The Safety Board acknowledges the concerns within the industry about potential legal actions and other issues regarding the retention and use (especially the provision to a third party) of records containing pilot performance evaluations. However, it should be recognized that a major portion of airline pilot training records involve checkrides given by designated pilot examiners. The designated examiners represent the FAA during such checkrides, so the records of their work are technically FAA records. The Safety Board believes that many of the industry concerns about the provision of records to a third party can be alleviated by having the performance/training and checking records for airline pilots forwarded to the FAA, similar to the manner in which airman's records are currently retained by the FAA. This system would permit airlines to request pilot records directly from the FAA and would resolve the problems faced by airlines in providing previous employee records. Similarly, continuity of the recordkeeping process would be maintained when an airline goes out of business. The Safety Board believes that state-of-the-art electronic scanning, storage, retrieval, and transfer methods would limit the effort and costs associated with developing such a system. Consequently, the Safety Board believes that the FAA should develop and maintain a storage and retrieval system that contains pertinent standardized information on the quality of pilot performance in activities that assess pilot skills, abilities, knowledge, and judgment during training, check flights, initial operating experience, and line checks.

The Safety Board continues to believe that airlines and the traveling public would benefit from more availability of pertinent information to airlines about the quality of the performance of applicants for pilot positions in previous piloting positions. Therefore, the Safety Board concludes that the FAA should require all airlines operating under 14 CFR Parts 121 and 135 and independent facilities providing training to the airlines to provide to the FAA pertinent standardized information on the quality of pilot performance in activities that assess pilot skills, abilities, knowledge, and judgment during training, check flights, initial operating experience, and line checks for incorporation into a storage and retrieval system.

In addition, the Safety Board believes that the FAA should require all airlines operating under 14 CFR Parts 121 and 135 to obtain records from the FAA's storage and retrieval system that contain pertinent standardized information

on the quality of pilot training and performance, for the purpose of evaluating applicants for pilot positions during the pilot selection and hiring process. Of course, such a requirement should include the appropriate privacy protections, should require the permission of the applicant before dissemination, and should provide for sufficient access to the records by an applicant to ensure accuracy of the records.

However, before the system discussed above can be effective, appropriate records on the training and performance of pilots must be developed and maintained. For example, the computer-based records generated by the AMR Eagle training center, provided to Flagship Airlines, contained an annotation of the dates when specific required activities were accomplished, but there were no amplifying comments regarding performance or strengths/weaknesses for reference of subsequent instructors, check airmen, or managers. Information concerning specific problems experienced, if any, were either not recorded, or were destroyed once training was completed. There was not even a record to indicate when extra training sessions were required. This not only eliminated the ability to evaluate the individual's performance, it also prevented management from evaluating the effectiveness of its syllabus. Further opportunity to evaluate both the training and the individual pilot was lost because AMR Eagle/Flagship did not require written comments during a pilot's initial operating experience or probationary year.

By contrast, the Flagship training records compiled during the captain's training by Flagship personnel, prior to transfer of all training to AMR Eagle in September 1993, reflected cause for possible concern. The records not only documented the captain's unsatisfactory progress, they reflected the maneuvers involved (single engine nonprecision approaches March 24, 1992, and crosswind takeoffs and landings, engine failures, and single engine missed approaches on April 29, 1992). Although these records were not available at the RDU base, they could have been reviewed by Flagship management for the RDU Base Manager, or sent to RDU via company mail for his own examination.

The captain had demonstrated adequate skills in routine operations that may have masked his deficiencies in some checking and oversight situations. However, his line flying performance caused several line pilots to speak to the Base Manager about the accident captain. In fact, the captain had even approached the Base Manager to discuss this situation on his own initiative. Although the Base Manager addressed the issues raised with the individuals making the comments, and offered the captain additional training/simulator time, there was no evidence that he attempted to review the captain's records. If the Base Manager had

reviewed the AMR Eagle computerized training records of the captain, he would not have found the annotation of the failed SD3-60 training periods (March 24, 1992 and April 29, 1992). Also, he would not have found any record of the failed J-3201 upgrade type rating of October 6, 1992. However, these failures were documented in records available in the Flagship training records at Nashville and might have prompted additional discussion/action by management. Rather than relying on a report from a first officer, the events calling the deficient performance of the accident captain to the attention of his Base Manager should have prompted some form of records review, discussions with other company personnel, and possibly a line check or check airman assessment.

The deficiencies in the company's recordkeeping, and the company's failure to use the records it had for safety enhancement, are best exemplified by the fact that following the accident, the Director of Operations stated that he had not reviewed the crew records. Moreover, although the Vice President of Operations had reviewed the records, he was still unaware that the captain had failed a check ride in the J-3201. In short, the lack of accessibility of and sufficient detail in the pilot records apparently prevented Flagship management from reviewing the captain's performance history, even when complaints from others and self-initiated comments from him were received. Moreover, the deficiency in the AMR Eagle/Flagship training records prevented Flagship management from ensuring that pilot problems were being addressed in training and from adequately monitoring substandard pilot performance trends.

The Safety Board previously investigated an accident³ in which it found that the recordkeeping of a major airline was inadequate to use for trend analysis or evaluation of an individual's performance during training. As a result, the Safety Board issued the following safety recommendation to the FAA:

A-94-24

Review the pilot recordkeeping systems of airlines operated under FAR Parts 121 and 135 to determine the quality of information contained therein, and require the airlines to maintain appropriate information on the quality of pilot performance in training and checking programs.

³Safety Recommendation A-94-24 was issued as a result of the American Airlines, Inc., DC-10-30 accident at Dallas/Fort Worth International Airport, Texas, April 14, 1993, NTSB/AAR-94/01.

In a response to the recommendation, the FAA Administrator issued Flight Standards Information Bulletin (FSIB) 94-16A, January 22, 1995, directing principal operations inspectors (POIs) to review their assigned operator's airman training recordkeeping procedures "...to ensure that quality control measures are adequate to maintain appropriate information on the quality of pilot performance in training and checking programs." The accident involving flight 3379 demonstrates a continuing need for positive FAA action to enhance the quality of information that airlines retain on each pilot. The Safety Board believes that the FAA's response to A-94-24 is ineffective because it does not require operators to keep and retain data that is identifiable with individual performance. The action taken, which is voluntary for the operator, may provide some measure of overall training program quality control, but it would not be useful in identifying individual weak pilots. At a minimum, the airlines should include specific information about the quality of the individual pilot's performance, preferably with instructor comments/evaluations, quantitative data, such as test scores, the number of training sessions, and the number of unsatisfactory checks (including maneuvers involved). Therefore, the Safety Board classifies Safety Recommendation A-94-24 "Closed-Unacceptable Action/Superseded." The Safety Board believes that the FAA should require all airlines operating under 14 CFR Parts 121 and 135 and independent facilities that train pilots for the airlines to maintain pertinent standardized information on the quality of pilot performance in activities that assess pilot skills, abilities, knowledge, and judgment during training, check flights, initial operating experience, and line checks and to use this information in quality assurance of individual performance and of the training program.

Therefore, as a result of its investigation of this accident, the National Transportation Safety Board recommends that the FAA:

Publish advisory material that encourages air carriers to train flightcrews in the identification of and proper response to engine failures that occur in reduced power conditions, and in other situations that are similarly less clear than the traditional engine failure at takeoff decision speed. (Class II, Priority Action) (A-95-98)

Review the organizational structure of the FAA surveillance of AMR Eagle and its carriers with particular emphasis on the positions and responsibilities of the Focal Point Coordinator and principal inspectors, as they relate to the respective carriers. (Class II, Priority Action) (A-95-99)

Ensure that all airplanes (other than the AMR Eagle J-3201 fleet) that currently use a Collins FPA-80 in lieu of a GPWS, under the provisions of 14 CFR 135.153, have installations that comply with Federal regulations. (Class II, Priority Action) (A-95-100)

Require all airlines operating under 14 CFR Parts 121 and 135 and independent facilities that train pilots for the airlines to maintain pertinent standardized information on the quality of pilot performance in activities that assess skills, abilities, knowledge, and judgment during training, check flights, initial operating experience, and line checks and to use this information in quality assurance of individual performance and of the training program. (Class II, Priority Action) (A-95-116)

Require all airlines operating under 14 CFR Parts 121 and 135 and independent facilities that train pilots for the airlines to provide the FAA, for incorporation into a storage and retrieval system, pertinent standardized information on the quality of pilot performance in activities that assess skills, abilities, knowledge, and judgment during training, check flights, initial operating experience, and line checks. (Class II, Priority Action) (A-95-117)

Maintain a storage and retrieval system that contains pertinent standardized information on the quality of 14 CFR Parts 121 and 135 airline pilot performance during training in activities that assess skills, abilities, knowledge, and judgment during training, check flights, initial operating experience, and line checks. (Class II, Priority Action) (A-95-118)

Require all airlines operating under 14 CFR Parts 121 and 135 to obtain information, from the FAA's storage and retrieval system that contains pertinent standardized pilot training and performance information, for the purpose of evaluating applicants for pilot positions during the pilot selection and hiring process. The system should have appropriate privacy protections, should require the permission of the applicant before release of the information, and should provide for

sufficient access to the records by an applicant to ensure accuracy of the records. (Class II, Priority Action) (A-95-119)

Chairman HALL, Vice Chairman FRANCIS, and Members HAMMERSCHMIDT and GOGLIA concurred in these recommendations.

By: 
Jim Hall
Chairman