

*REGIONAL AIR CARRIERS AND PILOT  
WORKFORCE ISSUES*



**Statement of James C. May  
President and CEO  
Air Transport Association of America, Inc. (ATA)  
before the  
Subcommittee on Aviation  
of the  
House Committee on Transportation and Infrastructure**

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**AIR TRANSPORT ASSOCIATION**

The crash of the Colgan Air aircraft near Buffalo on February 12, 2009 was a tragedy that has produced heartache for the relatives and friends of the victims of that accident. Words are faint consolation for their grief.

Two basic considerations need to guide us in the aftermath of that tragedy.

The first consideration is that in the aviation community, no accident is acceptable. We need to understand through rigorous and searching inquiry the cause of the Buffalo accident. Completion of the ongoing National Transportation Safety Board investigation will produce a far more complete picture than we have today of what so tragically unfolded that evening. Moreover, the Department of Transportation Inspector General recently began an examination of Federal Aviation Administration (FAA) oversight of certification, pilot qualification, training and other issues that will augment the NTSB effort. The “call to action” meeting that the Secretary of Transportation announced on Tuesday will enhance these two efforts. The FAA will host stakeholders at that meeting on June 15 to review pilot training, cockpit discipline and other issues associated with flight safety. We enthusiastically support this initiative. ATA and its members actively participated in last year’s FAA runway safety “call to action.” We look to the same type of involvement with this latest “call to action.”

The second consideration is that it is the certificate holder – the air carrier that has received the authority from the FAA to serve the public – that is ultimately responsible and accountable for the safety of its operations and for complying with the requirements that the FAA imposes on air carriers. The Inspector General recognized these roles in his testimony today.

It goes without saying but I will say it: ATA members are uncompromisingly focused on their responsibilities as certificate holders. They and their employees have achieved an extraordinary safety record because of that single-minded focus. This has occurred, I would emphasize, during the most turbulent era in our industry’s history. It is in the spirit of the pursuit of safety that I appear before you today.

Understandably, much has been written about the Buffalo accident. Speculation, however, is not the foundation for a meaningful response to any aviation accident. We need to get it right. That is why we all rely on the NTSB in these situations. After its investigation is concluded, the Board will prepare and issue a detailed narrative report that analyzes the investigative record, identifies the probable cause of the accident and makes specific recommendations for fixing the causes of the accident.

That kind of rigor is indispensable in developing a fact-based, informed and effective response to the accident. It is the kind of diligence that characterizes other safety-related efforts in our industry. We approach safety issues collaboratively with commitment and know-how within the bounds of the Federal Aviation Regulations (FARs).

In the airline industry, safety is the highest priority. That is a shared commitment and we work closely with other members of the aviation community to achieve it. Together with the FAA, manufacturers, labor unions and other interested parties, we have achieved an extraordinary safety record. That impressive accomplishment, however, does not mean that we can rest on our laurels. We continuously pursue safety. Improving safety is work that is never done; we always seek to improve.

Commercial aviation has built this record through a disciplined and analytical approach to improving safety performance. That scrutiny includes benefiting from experience and from a forward-looking search to identify emerging issues. The Commercial Aviation Safety Team (CAST), for example, brings together stakeholders to improve safety performance by applying data-driven analyses to spot issues before accidents occur and to establish safety priorities. Increasing reliance on two industry-led safety programs, the Aviation Safety Action Program (ASAP), which encourages voluntary reporting of safety issues and events that come to the attention of employees of certain certificate holders, and the Flight Operational Quality Assurance (FOQA) program, which involves the collection and analysis of data recorded during flight to improve safety, have also added immeasurably to our knowledge. This empirical approach,

coupled with the expertise and commitment of our front-line employees, provides the underpinning for industrywide safety efforts.

Participation in these programs underscores that ATA members' efforts go well beyond compliance with governmental regulatory directives. This willingness to exceed minimum requirements is often overlooked. It is tightly woven into the safety culture of airlines, whether they are mainline or regional.

No accident or incident is acceptable. We seek to learn from each event. Consequently, ATA has formed a Senior Advisory Task Force to address the matters raised during the recent NTSB hearing about the Buffalo accident. The task force is comprised of airline presidents, chief operating officers and their peers. It will ensure that our support of the FAA, airlines, unions and others is responsive, targeted and thorough.

ATA member airlines highly value their relationships with regional airlines and the customer benefits those arrangements provide. Customers, communities and the marketing and operating carriers benefit immensely.

The bedrock principle in civil aviation is that the entity to which the FAA has issued a certificate is solely responsible for its activities. Whether that entity is an air carrier, an airman or a dispatcher, that responsibility cannot be delegated or assumed by others. That principle avoids any confusion about ultimate responsibility, an absolutely essential consideration in promoting safety. It is a principle that dates back to 1938, when Congress created the Civil Aviation Authority, the predecessor of the FAA.

As separate regulated entities, regionals are independent of mainline airlines. As I noted above, they hold operating authority that the FAA has granted them. The FAA certifies regionals under Federal Aviation Regulation Part 121. This means that the certificate holder - the regional airline - maintains the responsibility for and direct control of its operations and safety programs. The FAA has the mandate to assure compliance with Part 121 and other FAR requirements.

We should also remember that in the mid-1990s, in evaluating the need for improvements in the regulatory structure under which commuter airlines - the former term for regional airlines - operated, the FAA responded with the support of ATA and its members by requiring them to adhere to FAR Part 121, the same regulation under which mainline airlines operate. As a result, the rule that became effective on December 20, 1995 imposed a "one-level-of-safety" standard that continues to this day. It required aircraft with 10 or more passenger seats and all turbojets operated in scheduled passenger service to operate under and comply with FAR Part 121 operational requirements. These included dispatch requirements and the use of certificated dispatchers, new flight/duty time rules, manuals and procedures for flight and ground personnel, cabin safety and flight attendant requirements for 20- to 30-seat airplanes, and new training rules.

Moreover, the Department of Transportation for over a decade has required in 14 CFR Part 257 that code-share arrangements be disclosed to customers before they purchase a ticket. This "operated by" language underscores the importance that the government has recognized in maintaining the distinction between the mainline airline and the regional airline.

The FAA's implementation of uniform mainline and commuter regulatory requirements has raised questions about mainline and regional operating environments. The most significant of those concerns and our responses follow.

**"Two-tiered safety environment."** As noted previously, since 1995 the FAA has imposed one level of safety on the air carrier industry - whether with respect to training, flight deck crew competency, etc. If the NTSB or FAA determines that regional airline performance within that unitary regulatory structure requires additional attention, it should reformulate its compliance efforts as necessary.

**Flight/duty time regulations.** An issue that has arisen in the Buffalo accident is the role of flight-deck personnel commuting. That, it should be clear, is not a flight/duty time issue. Commuting is within the

exclusive control of the pilot or copilot. It is expected, and the law assumes, that they will report fit to work. It is the responsibility of the crew member to inform the carrier if he/she is unable to fly because of fatigue, whether because of commuting or for any other reason. That is why Part 121 airlines staff reserve crew members.

**Flight deck crew compensation.** With but one exception, pilots at all larger regional airlines are represented by unions and they work in a seniority-based system. Compensation is a function of collective bargaining. Neither legislation nor regulation can effectively peg what is the right compensation in such a system of negotiated wages, benefits and working conditions.

**Sterile cockpit rule.** The FAA imposed the sterile cockpit rule in 1981. Its longstanding prohibition against “nonessential conversations within the cockpit” is well-known. To the extent that compliance with the rule is a concern at any Part 121 carrier, it is a matter for the FAA to pursue.

**Centralized pilot record database.** A centralized database of pilot records would make it easier to evaluate the backgrounds of applicants for flight deck positions. We urge the FAA to determine if such a database can be efficiently implemented. To be successful, however, it must be complete. Results of all pertinent actions relating to the pilot’s competency must be recorded and accessible to an airline evaluating an applicant.

### *Conclusion*

We will work diligently with other stakeholders in evaluating and responding to the results of the NTSB investigation of the Buffalo accident and the Inspector General’s assessment of the FAA regulatory oversight program. Next week’s FAA “call to action” meeting, which we look forward to participating in, should contribute appreciably to this effort. It is in that informed context that any further action to improve safety should be examined.