Aircraft Accident Investigation Authority
of the Bahamas

Aviation Short Investigation Final Report

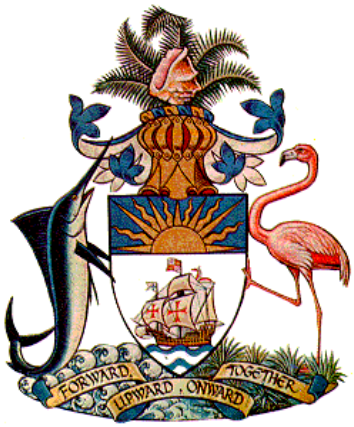
Abrupt Maneuver (Aborted Takeoff)

Boeing 737-900ER – N900DU

Lynden Pindling Int'l Airport (MYNN), Nassau, Bahamas
8th February 2024

AAIA Aviation Occurrence Investigation
Report # OCC-2024/0011

Date of Final Report
2nd December 2024



Released in accordance with Section 25 of the Aircraft Accident Investigation Authority Act (AAIA) 2019 and Section 1.445 of the AAIA Regulations 2021.

Publishing information

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About the AAIA

The Aircraft Accident Investigation Authority (AAIA) is the independent accident investigation agency under the Bahamas Ministry of Energy &Transport (MOET) charged with the responsibility of investigating all aviation accidents and serious incidents in the Bahamas.

The AAIA's function is to promote and improve safety and public confidence in the aviation industry through excellence in:

- Independent investigation of aviation accidents and other safety occurrences
- Safety data recording, analysis and research
- Fostering safety awareness, knowledge and action.

The AAIA does not investigate for the purpose of apportioning blame or to provide a means for determining liability. At the same time, an investigation report must include factual material of sufficient weight to support the analysis and findings. At all times the AAIA endeavors to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

The AAIA performs its functions in accordance with the provisions of the Aircraft Accident Investigation Authority Act 2019 and Regulations 2021, International Civil Aviation Organization (ICAO) Annex 13 and, where applicable, relevant international agreements.

The Aircraft Accident Investigation Authority is mandated by the Ministry of Energy & Transport to investigate aviation accidents and incidents, determine probable causes of accidents and incidents, issue safety recommendations, study transportation safety issues and evaluate the safety effectiveness of agencies and stakeholders involved in air transportation. The object of a safety investigation is to identify and reduce safety-related risk. AAIA investigations determine and communicate the safety factors related to the transport safety matter being investigated.

The AAIA makes public its findings and recommendations through accident reports, safety studies, special investigation reports, safety recommendations and safety alerts. When the AAIA issues a safety recommendation, the person, organization or agency is required to provide a written response without delay. The response shall indicate whether the person, organization or agency accepts the recommendation, any reasons for not accepting part or all of the recommendation(s), and details of any proposed safety action(s) resulting from the recommendation(s) issued.

About this report

Decisions regarding whether to conduct an investigation, and the scope of an investigation, are based on many factors, including the level of safety benefit likely to be obtained from an investigation. For this occurrence, a limited-scope, fact-gathering investigation was conducted in order to produce a short summary report, and allow for greater industry awareness of potential safety issues and possible safety actions.

AIRCRAFT ACCIDENT

INVESTIGATION AUTHORITY

Registered Owner:	Delta Airlines
Manufacturer:	Boeing
Aircraft Type:	737-900ER
Nationality:	United States
Registration:	N900DU
Place of Accident:	Lynden Pindling Int'l Airport (MYNN), Nassau, Bahamas
Date and Time:	8th February 2024; 1:31 pm local (1831 UTC)
Notification:	Civil Aviation Authority Bahamas (CAA-B) National Transportation Safety Board (NTSB) United States International Civil Aviation Organization (ICAO)
Investigating Authority:	Aircraft Accident Investigation Authority, Ministry of Energy &Transport
Investigator in Charge:	Kendall Dorsett Jr
Accredited Representatives:	Doug Brazy (NTSB) United States
Releasing Authority:	Aircraft Accident Investigation Authority
Date of Final Report Publication:	2nd December 2024

History of Flight

On 8th February 2024 at approximately 1:31 pm local time (1831 UTC), a Boeing 737-900ER aircraft with United States registration N900DU, operated by Delta Airlines as Delta Flight # 1965 (DAL1965), was given instructions by Nassau air traffic control to cancel its takeoff clearance for runway 14 at the Lynden Pindling International Airport (MYNN), Nassau, Bahamas, due to the execution of two consecutive go arounds for the intersecting runway 10.

The scheduled commercial flight operated under ***Title 14 US CFR Part 121*** and had a final destination of Hartsfield-Jackson Atlanta International Airport (KATL), Atlanta, Georgia, USA. There was a total of 134 persons on board the aircraft (128 passengers, 6 crew).

Reports received indicate that at approximately 1:29 pm local time (1829 UTC), the pilot in command of a Cessna Citation 680A with United States registration N926QS, while on final approach for landing on runway 10 at MYNN, executed a go around after the aerodrome controller (local controller[1]) did not issue a final clearance to land on runway 10 after the pilot advised that he was unable to comply with the aerodrome controller's request to land and hold short (LAHSO[2]) of runway 14.

The next aircraft in sequence for landing runway 10 at MYNN, a Bombardier CRJ200 with Canadian registration C-GDTD, operating as FEX850, subsequently was forced to execute a go around at approximately 1:31 pm (1831 UTC) as the aerodrome controller had not issued a landing clearance at the point of the aircraft reaching the published missed approach point (as identified by "MAPt" on figures1 and 2).

During the period of these consecutive go arounds for runway 10, operations were also being conducted on intersecting runway 14 with departures by a Beechcraft King Air 200 operating as TJJ800 at 1:27 pm (1821 UTC) and by an Embraer E110 operating as PNP978 at 1:30 pm (1830 UTC).

It would appear that the complex operations may have overwhelmed the aerodrome controller, having to also incorporate into sequencing, two additional aircraft as N900DU was instructed to position for a departure from runway 14 while a Beechcraft King Air 200 with United States registration N712CY was established on short final approach for landing runway 14 at a distance of approximately less than 3 NM from the threshold of runway 14.

[1] Local Controller - assumes separation responsibilities for aircraft in a certain radius around the airport from specified altitudes to the ground and on the runways

[2] LAHSO – (Land and hold short operations) Operations which include simultaneous takeoffs and landings and/or simultaneous landings when a landing aircraft is able and is instructed by the controller to hold-short of the intersecting runway/taxiway or designated hold-short point. Pilots are expected to promptly inform the controller if the hold short clearance cannot be accepted.

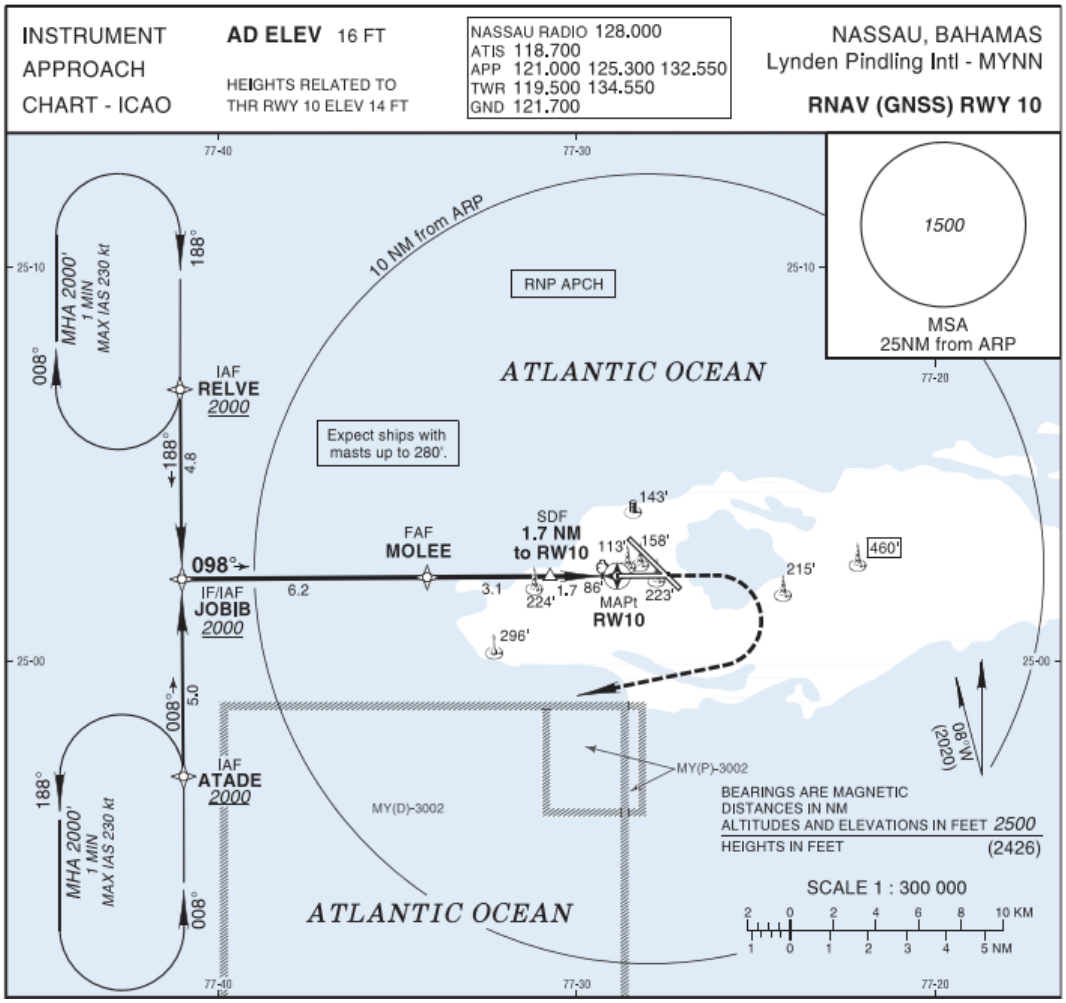

Fig.1 Plan view of Instrument Approach Procedure (RNAV Runway 10) at MYNN showing MAPt

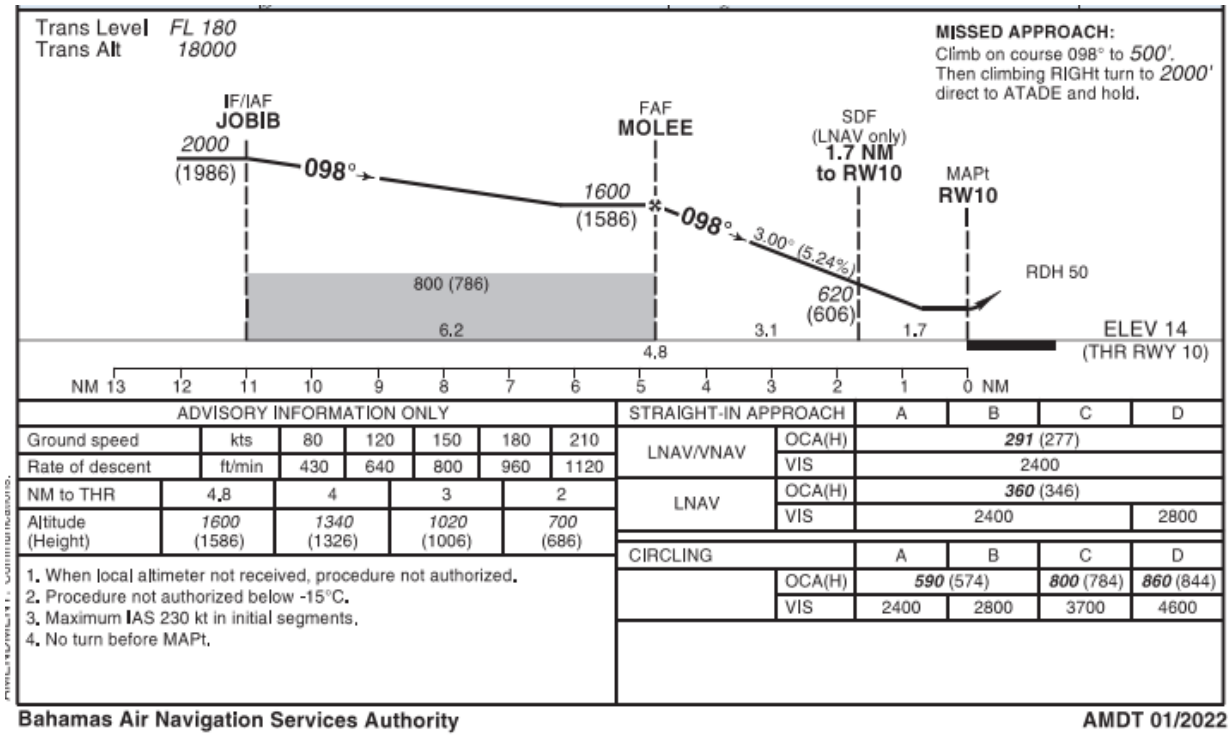

Fig.2 Profile view of Instrument Approach Procedure (RNAV Runway 10) at MYNN showing MAPt

The aerodrome controller issued N900DU (DAL1965) clearance for an immediate takeoff at approximately 1:31 pm, but quickly had to issue a cancel takeoff clearance instruction just a few seconds later as CRJ200 FEX850 (C-GDTD) was maneuvering through the potential flight path of N900DU as it climbed to altitude. The pilot in command of N900DU, who was the pilot flying, advised that he had already added power to 40% of N1[3], and after engine stabilization, applied takeoff thrust and the aircraft accelerated up to a speed of approximately 90 knots before he abruptly had to abort takeoff.

A witness account from a passenger on board the aircraft indicated that the abrupt braking maneuver resulted in several of the overhead bins becoming opened. The pilots were able to bring the aircraft to a stop and exited the runway at taxiway Echo.

The flight crew conducted checks in accordance with manufacturer and operators standard operating procedures and returned to the ramp area for an adequate period of time, to allow for cooling of the brakes before departure. There were no injuries reported in relation to this occurrence.

The flight, although significantly delayed, was ultimately able to continue to its final destination of KATL without further incident.

[3] N1 - refers to the rotational speed of the low speed spool which consists of the fan, the low pressure compressor and the low pressure turbine, all of which are connected by a concentric shaft. On many jet engines, N1 is the primary indication of engine thrust.

Injuries to Persons

Injuries	Crew	Passengers	Total
Fatal	0	0	0
Serious	0	0	0
Minor	0	0	0
None	6	128	134
TOTAL	6	128	134

Aircraft Information

Aircraft Manufacturer	**Registration**
Boeing	N900DU
Serial Number	**Registered Owner**
62779	Delta Airlines
Model/Series	**Aircraft Category**
737-900ER	Transport
Engine Manufacturer	**Engine Type**
CFM INTL.	CFM56 SERIES

The Boeing 737-900ER is a twin-engine short-to-medium-range narrow body airliner produced by the American manufacturer Boeing Commercial Airplanes.

The Boeing 737-900 is together with the 737-600, 737-700 and 737-800 member of the 737-Next Generation-Family.

Boeing 737-900ER is an enhanced version of the narrow-body passenger aircraft Boeing 737-900. It was developed to increase the range and passenger capacity.

The aircraft has a length of 42.1 meters, a wingspan of 35.8 meters, and a height of 12.5 meters. The maximum takeoff weight is 85,139 kg, and the maximum range is 6,510 km.

Boeing 737-900ER can carry up to 215 passengers depending on the cabin configuration. It is equipped with two CFM International CFM56-7B27 engines, each with a thrust of 27,300 pounds.

Aerodrome Information

The Lynden Pindling International Airport (MYNN) is the main gateway to the Bahamas and is situated on the island of New Providence. It is a Government owned Port of Entry operated by the Nassau Airport Development Company (NAD).

Bahamas Customs and Immigration Services, as well as Air Traffic Services and MET Weather are available 24 hours.

The aerodrome is serviced by two (2) intersecting runways 10/28 and 14/32. Below taken from Bahamas Aeronautical Information Publication (AIP) Amendment 01/2024 (08AUG2024):

MYNN AD 2.12 RUNWAY PHYSICAL CHARACTERISTICS

RWY Designator	*TRUE BRG*	*Dimension of RWY (M)*	*Strength (PCN) and surface of RWY and SWY*	*THR coordinates RWY end coordinates THR geoid undulation*	*THR elevation and highest elevation of TDZ of precision APP RWY*
1	*2*	*3*	*4*	*5*	*6*
10	089.00°	2530 x 46	PCN 52/F/A/X/T SWY: NIL	250209.45N 0772851.96W END: NIL GUND: NIL	THR 14 FT TDZ 15 FT
28	269.00°	2530 x 46	PCN 52/F/A/X/T SWY: NIL	250209.96N 0772724.79W END: NIL GUND: NIL	THR 12 FT TDZ 15 FT
14	134.00°	3330 x 46	PCN 55/F/A/X/T SWY: NIL	250306.46N 0772832.20W END: NIL GUND: NIL	THR 13.0 FT TDZ 16.0 FT
32	314.00°	3330 x 46	PCN 55/F/A/X/T SWY: NIL	250150.40N 0772707.73W END: NIL GUND: NIL	THR 13 FT TDZ 14 FT

The aerodrome has an elevation of 16 feet and airspace is classified as Class D airspace extending upward from the surface to 1,500 feet AMSL within a 15 NM radius of the aerodrome (Nassau Control Zone).

Aerodrome firefighting category is Category 8 (with higher category capability).

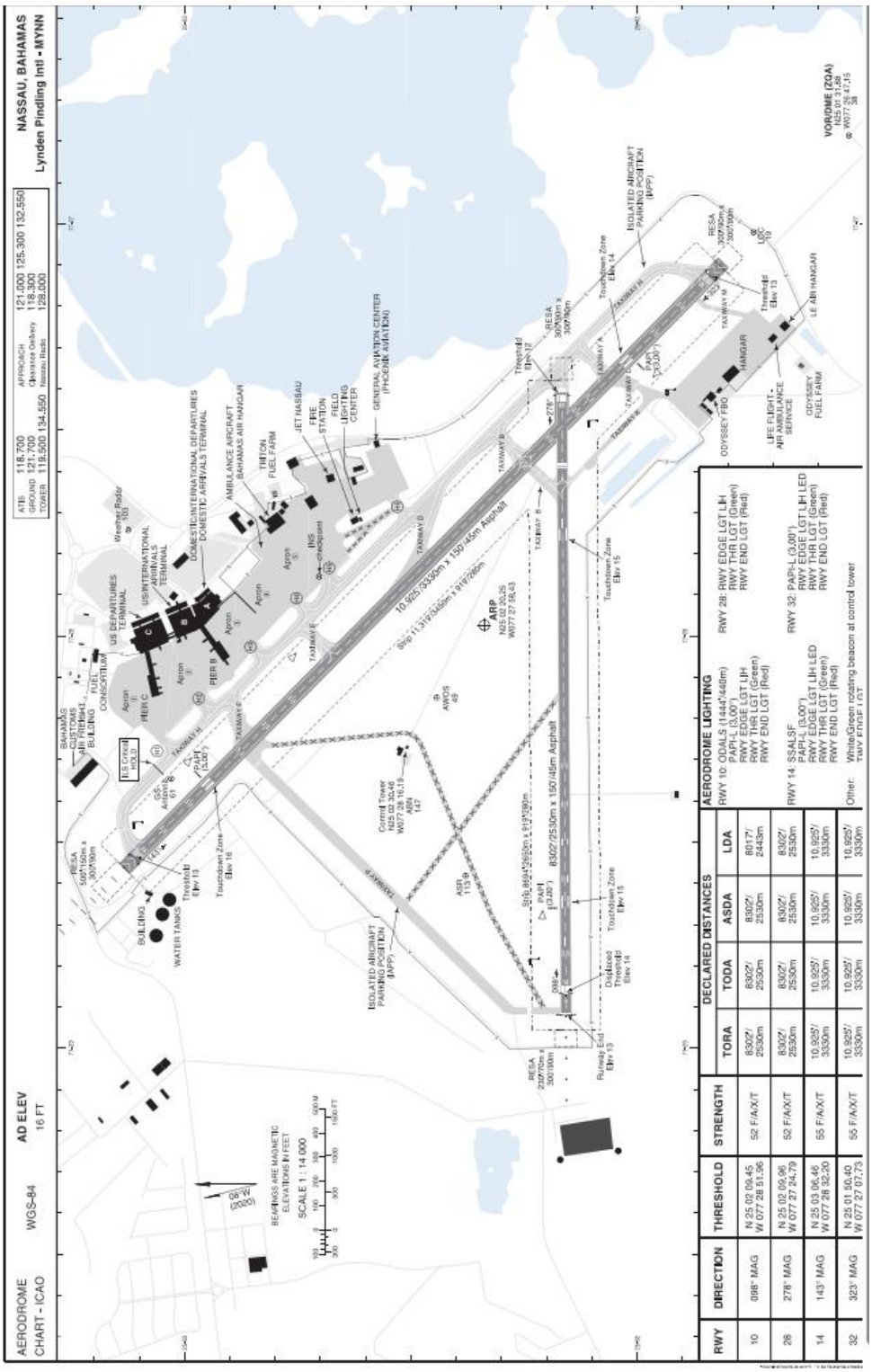

Fig. 3: MYNN Aerodrome Chart

Occurrence Information

Crew Injuries	Aircraft Damages
0	None
Passenger Injuries	**Aircraft Fire**
0	None
Ground Injuries	**Aircraft Explosion**
0	None
Total Injuries	**Latitude/Longitude**
0	

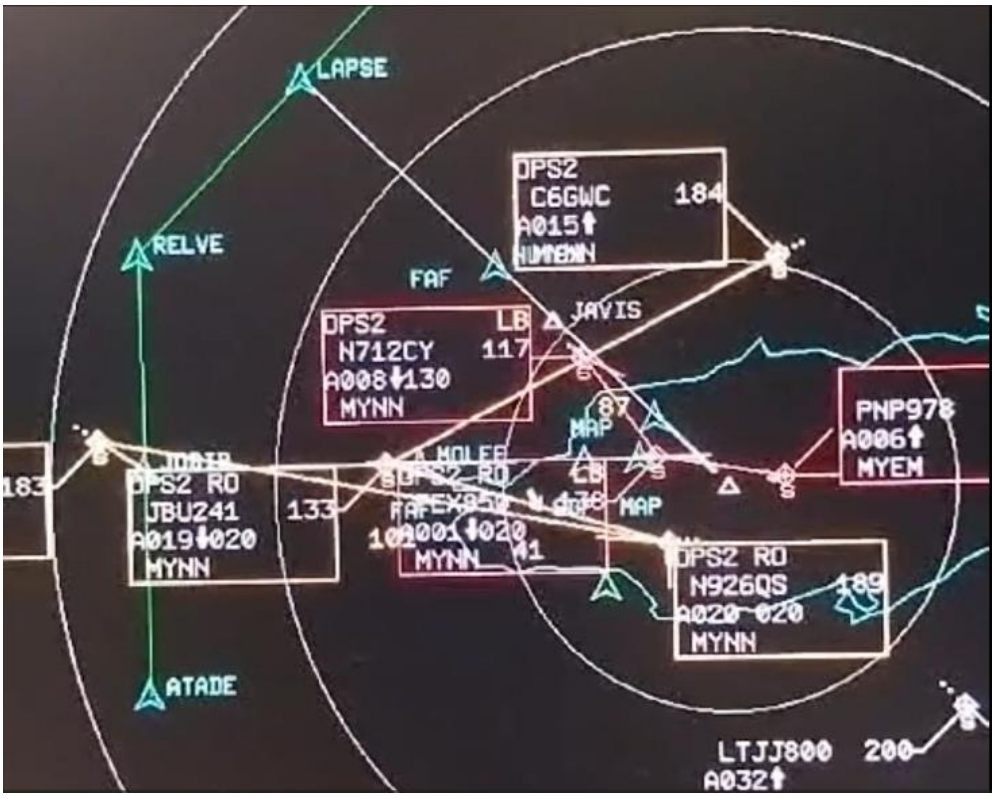

Fig.4: MYNN Radar scope at point of issuance of abort takeoff to N900DU

Fig.5: MYNN Layout and aircraft positioning

Investigation Findings

Pilots

The pilot in command was 64 years old at the time of the occurrence and possessed an Airline Transport Pilot's license issued by the Federal Aviation Administration (FAA) on the 8th June 2008 with ratings for Airplane Multi-Engine Land and Airplane Single-Engine Land with the limitation "***B-737 CIRC. APCH VMC Only***". Type ratings were held for the Boeing 737, 757 and 767 aircraft.

The pilot in command possessed a valid First Class medical certificate issued by the FAA in October 2023 with the limitation "***Must Use Corrective Lenses to Meet Vision Standards At All Required Distances***".

Approximately 18,043 total hours of flight time was accumulated with approximately 6,932 hours of flight time at Delta Airlines. The most recent proficiency check prior to the occurrence was completed on the 11th January 2024.

The second in command was 41 years old at the time of the occurrence and possessed an Airline Transport Pilot's license issued by the Federal Aviation Administration (FAA) on 13th April 2022 with ratings for Airplane Multi-Engine Land and Airplane Single-Engine Land with the limitation "***B-737 CIRC. APCH VMC Only***". Type ratings were held for the Boeing 707, 702 and 737 aircraft.

The second in command possessed a valid First Class medical certificate issued by the FAA in February 2024 with the limitation "***Must Use Corrective Lenses to Meet Vision Standards At All Required Distances***".

The most recent proficiency check prior to the occurrence was completed on 21st September 2023.

Aerodrome Controller (Local Controller)

The Aerodrome Controller was 32 years old at the time of the occurrence and completed On the Job Training (OJT) Certification with the Bahamas Air Navigation Services Authority (BANSA) for Aerodrome Control on the 21st September 2023.

The aerodrome controller possessed a Class 3 medical certificate with no waivers or limitations issued by the Civil Aviation Authority of the Bahamas on 25th February 2019 with an expiration date of 28th February 2023.

Weather

Meteorological Information:

Conditions at Accident site	**Condition of Light**
Visual Meteorological Conditions	Day
Observation Facility Location	**Observation Time**
Lynden Pindling Int'l Airport (MYNN)	1800 UTC
Distance from Accident Site	**Temp /Dewpoint**
N/A	24° C/12° C
Lowest Cloud Condition	**Wind**
FEW025	080/09 knots
Altimeter Setting	**Visibility**
30.16 in. HG	>6 statute miles

Communication

The frequency utilized for MYNN Tower control 119.500 MHz was operational with no issues identified during the period of this occurrence.

Although there may have not been any technical issues observed with respect to communication equipment, it became apparent that the aerodrome controller became overwhelmed at a certain point within the last 5 – 6 minutes prior to the occurrence as successive go-arounds where initiated by pilots after landing clearances were not communicated to them in a timely manner.

Other Information

The Bahamas Air Navigation Services Authority (BANSA) issued NOTAM[4] A0049/24 indicating the temporary closure of runway 14/32, which is the primary runway at MYNN, between the hours of 1400 – 1800 UTC (9:00 am – 1:00 pm local) on the day of the occurrence.

Subsequently, operations were limited to runway 10/28 for the stipulated time period. After the period of closure had ended, operations resumed on runway 14/32. During the period prior to the occurrence, operations were being conducted on both runway 14 and runway 10 with staggered arrivals and departures.

Arrivals and Departures

AIRCRAFT ID	TYPE	ATA	ATD	MIS-APP	ABORTED T/O	RWY
LTJJ800	BE20		1827UTC			14
N926QS	C68A			1829UTC		10
PNP978	E110		1830UTC			14
FEX850	CRJ2			1831UTC		10
DAL1965	B739				1831UTC	14
N712CY	BE20	1832UTC				14

ATA – Actual Time of Arrival ATD – Actual Time of Departure

After the reopening of runway 14/32, it was apparent that the sequencing being utilized was for aircraft arrivals to be facilitated by runway 10, and aircraft departures to be facilitated by runway 14.

However, there seemed to be a lack of coordination between aerodrome control and approach control as the vectoring of N712CY to runway 14 was not anticipated by the aerodrome controller and only exacerbated the already deteriorating situation presented by the execution of two successive go-arounds for runway 10.

[4] NOTAM – (Notice to Airman) notice containing information essential to personnel concerned with flight operations but not known far enough in advance to be publicized by other means

Of significant note also is the fact that there was inadequate supervision provided within the control tower, as there was absent, a person to perform the duties of a tower cab supervisor. The individual in this role would be responsible for the overall direction of operations within the control tower during a specified period.

Analysis

The AAIA does not investigate for the purpose of apportioning blame or to provide a means for determining liability. At the same time, an investigation report must include factual material of sufficient weight to support the analysis and findings.

At all times the AAIA endeavors to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

Within the air traffic control environment, it is understood that there are certain periods of operation that are more susceptible to the occurrence of human error due to the specific nuances or complexities that may be involved.

The return to normal operations within the air traffic control environment, as was the case in this occurrence where runway 14/32 was reopened at 1800 UTC (1:00 pm), is one such period where operational vulnerabilities can emerge as it requires adequate and efficient communication and coordination between personnel within the environment.

When a review of the air traffic control audio recording and radar playback was conducted, it was apparent that the aerodrome controller became overwhelmed after the point at which the pilot in command of N926QS was unable to accept a land and hold short of runway 14 instruction.

It also became apparent that there was a lapse in the coordination between the aerodrome controller and approach control as the aerodrome controller was operating under the impression that runway 10 was being utilized for arrivals only and runway 14 was for departures only.

The sequencing of N712CY for landing on runway 14 by approach control would have subsequently been unexpected by the aerodrome controller.

Human Factors Considerations

Recognizing that the occurrence of an unsafe act is not merely caused by one action or omission of an action, an assessment was conducted utilizing human factors principles to identify casual elements that may have sequentially led to the event.

The Human Factors Analysis and Classification System (HFACS), the well-known framework developed by Dr. Scott Shapell and Dr. Doug Weigmann based on James Reason's Swiss Cheese Model[5] of accident causation, was utilized to identify and help assess the deficiencies within this context.

[5] Swiss Cheese Model - originally proposed by James Reason, likens human system defences to a series of slices of randomly-holed Swiss Cheese arranged vertically and parallel to each other with gaps in-between each slice.
Reason hypothesizes that most accidents can be traced to one or more of four levels of failure; organizational influences, unsafe supervision, preconditions for unsafe acts, the unsafe act themselves.

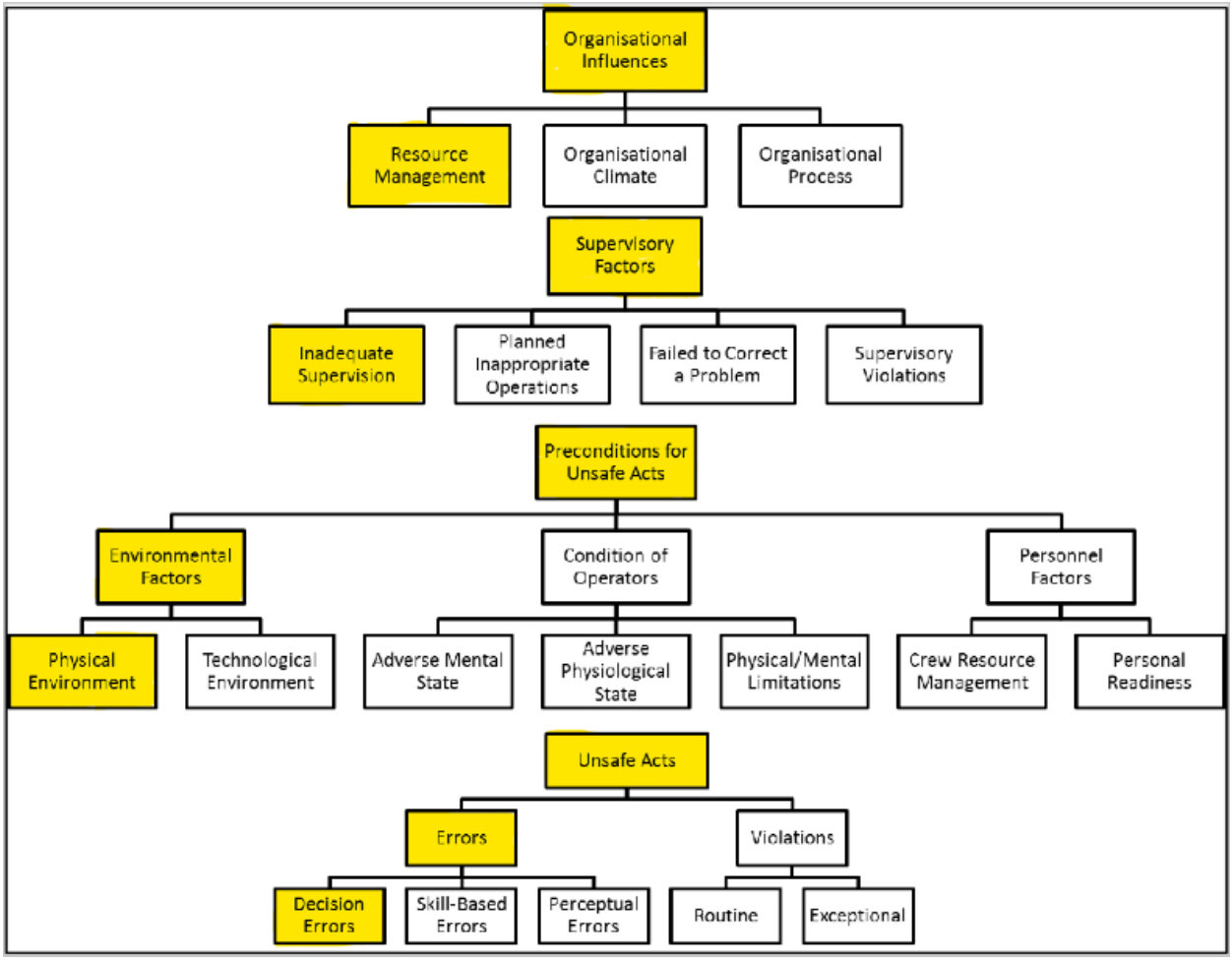

Fig.6: HFACS Framework

Application of the HFACS framework within the context of this occurrence allowed for there to be a comprehensive analysis of the various factors that may have been contributory to the occurrence taking place.

In keeping with the taxonomy from the HFACS framework, the ***Unsafe Act*** in this instance was identified as most applicable to ***Decision Errors*** whereby it was apparent that successive decisions made by the aerodrome controller, including not issuing landing clearances to both N926QS and C-GDTD (FEX850), where critical and the situation deteriorated in the aftermath.

With regard to the element of ***Precondition for Unsafe Acts***, what is of significant importance in this occurrence is the ***Physical Environment*** relative to the operations being conducted at the aerodrome which were impacted by the temporary closure of runway 14/32.

The return to normal operations with the reopening of runway 14/32, required efficient and effective communication and coordination between aerodrome control and approach control as adjustments would be necessary to make the operational transition.

The ***Supervisory Factors*** element was identified via the lack of a Tower Cab Supervisor in the control tower which falls under the category of ***Inadequate Supervision***. It would not be unreasonable to expect that the presence of a Tower Cab Supervisor would have possibly mitigated against the events unfolding in the manner in which they did.

With reference to the ***Organizational Influences,*** the lack of a Tower Cab Supervisor to provide adequate supervision within the control tower can be linked to the ***Resource Management*** of the Bahamas Air Navigation Services Authority (BANSA) as an organization, which is required to ensure that adequate human resources are in place to facilitate the safe, orderly and expeditious flow of air traffic.

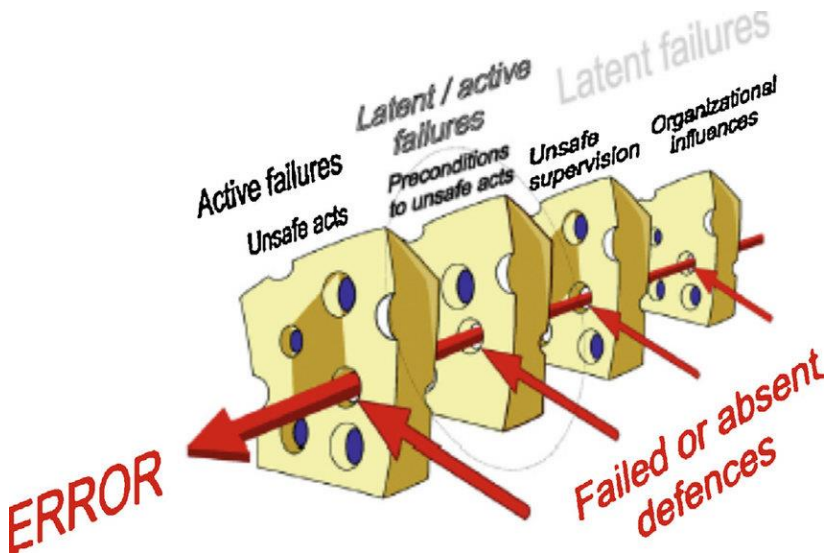

Fig.7 Swiss Cheese Model of Accident Causation

Findings

These findings should not be read as apportioning blame or liability to any particular organization or individual.

1) The aircraft was certified, registered and equipped in accordance with applicable United States Regulations and approved procedures.

2) The aircraft was maintained in accordance with the manufacturers' specifications and existing United States Regulations and approved procedures.

3) The pilot in command possessed an Airline Transport Pilot's license issued by the Federal Aviation Administration (FAA) on June 8th 2008 with ratings for Airplane Multi-Engine Land and Airplane Single-Engine Land with the limitation "***B-737 CIRC. APCH VMC Only***". Type ratings were held for the Boeing 737, 757 and 767 aircraft.

4) The pilot in command possessed a valid First Class medical certificate issued by the FAA in October 2023 with the limitation "***Must Use Corrective Lenses to Meet Vision Standards At All Required Distances***".

5) The second in command possessed an Airline Transport Pilot's license issued by the Federal Aviation Administration (FAA) on April 13th 2022 with ratings for Airplane Multi-Engine Land and Airplane Single-Engine Land with the limitation "***B-737 CIRC. APCH VMC Only***". Type ratings were held for the Boeing 707, 702 and 737 aircraft.

6) The second in command possessed a valid First Class medical certificate issued by the FAA in February 2024 with the limitation "***Must Use Corrective Lenses to Meet Vision Standards At All Required Distances***".

7) The Aerodrome Controller (Local Controller) completed aerodrome certification with the Bahamas Air Navigation Services Authority (BANSA) on the 21st September 2023.

8) The Aerodrome Controller possessed a Third Class medical certificate issued by the Civil Aviation Authority Bahamas (CAA-B) on 25th February 2019 with an expiration date of 28th February 2023.

9) Weather was not a factor in this occurrence.

10) There was no evidence of any defect or malfunction in the aircraft that could have contributed to the occurrence.

11) NOTAM A0049/24 was issued by BANSA indicating the temporary closure of runway 14/32 at MYNN between 1400 – 1800 UTC (9:00 am – 1:00 pm local).

12) After the period of closure, operations were conducted on both runway 14 and runway 10 with staggered arrivals and departures.

13) A Tower Cab Supervisor was not present in the control tower during this period of operation.

14) N926QS, while on final approach for landing on runway 10 at MYNN, executed a go-around after the aerodrome controller did not issue a final clearance to land on runway 10 at approximately 1:29 pm (1829 UTC).

15) C-GDTD, operating as FEX850, was forced to execute a go-around for runway 10 at approximately 1:31 pm (1831 UTC) as the aerodrome controller had not issued a landing clearance at the point of the aircraft reaching the published missed approach point.

16) N900DU (DAL1965) was issued clearance for an immediate takeoff at approximately 1:31 pm, but a cancel takeoff clearance instruction was issued by the aerodrome controller just a few seconds later as C-GDTD was maneuvering through the potential flight path of N900DU after executing a go-around.

17) The pilot in command of N900DU aborted takeoff from runway 14 and was able to exit the runway at taxiway Echo.

Probable Cause

The AAIA has determined the probable cause of this occurrence to be the deterioration of separation minima between aircraft operating within the innermost core (5 nm radius) of the Nassau Control Zone which resulted in the necessary issuance of a cancel takeoff clearance to an aircraft (N900DU) on takeoff roll.

Contributing factors include:

- Inefficient intra-facility coordination.
- Inefficient supervision within controlled environment.

Safety Recommendations

In accordance with the ***Aircraft Accident Investigation Authority Act 2019 Part V Reports and Recommendations; Subpart 27 Safety Recommendations***, the AAIA issued the following safety recommendations to the Civil Aviation Authority Bahamas (CAA-B) and the Bahamas Air Navigation Services Authority (BANSA):

- **SR2024-01** - The AAIA recommends that the Civil Aviation Authority Bahamas (CAA-B) conduct an assessment of the status of Air Traffic Controller licenses and medicals held by employees of the Bahamas Air Navigation Services Authority (BANSA) to ensure compliance with CAA-*B* ***CAR LIC Licensing Regulations Chapter 1 LIC.005 (b)(2)(ii)*** and ***CAR LIC.1710 (b) Age and Medical Requirements.***

- **SR2024-02** - The AAIA recommends that the Bahamas Air Navigation Services Authority (BANSA) conducts an internal review of the status of Air Traffic Controller licenses and medicals held by its employees to ensure compliance with CAA-*B* ***CAR LIC Licensing Regulations Chapter 1 LIC.005 (b)(2)(ii)*** and ***CAR LIC.1710 (b) Age and Medical Requirements.***

- **SR2024-03** - The AAIA recommends that BANSA conduct an assessment of its standard operating procedures relative to conducting simultaneous runway operations (when one runway is used specifically for arrivals and the other used specifically for departures) to identify any potential deficiencies that may exist.

- **SR2024-04** - The AAIA recommends that BANSA formulate a plan of action to ensure that there is a Tower Cab Supervisor present in the control tower during periods of peak or complex operations.

- **SR2024-05** - The AAIA recommends that BANSA implement a mechanism to ensure that air traffic controllers are systematically and continuously provided with opportunities to undergo training for emergency and non-routine situations.

As of the date of publication of Draft Final Report, the following actions have been taken in relation to the Safety Recommendations issued:

- **SR2024-01** – The Civil Aviation Authority Bahamas (CAA-B) consulted with the Bahamas Air Navigation Services Authority (BANSA) to ascertain the status of Air Traffic Controller licenses and medicals held by employees of the Bahamas Air Navigation Services Authority (BANSA) to ensure compliance with applicable regulations.

- **SR2024-02 –** The Bahamas Air Navigation Services Authority (BANSA) conducted an internal review and Air Traffic Controllers found not in compliance were given ten (10) days to complete medicals followed by license applications.

- **SR2024-03** – The Bahamas Air Navigation Services Authority (BANSA) completed a review of the Standard Operating Procedure (SOP) and concluded that the SOP is correct, however, the deficiency identified was deviation from the SOP. Mitigation was facilitated via the proposed provision of refresher training on standard operating procedures for simultaneous runway operations and the importance of remaining in compliance with the SOP.

- **SR2024-04** – BANSA made proposal to ensure that an Operation Supervisor/Controller-in-Charge is scheduled on the Roster in the Tower during peak or complex operations. Peak operation periods are considered daily between 11:00 a.m. to 3:00 p.m. local time.

- **SR2024-05** – BANSA amended its annual refresher training program to incorporate into the training similar non-routine and emergency scenarios.

As a result of the actions taken above, the status of the issued Safety Recommendations are as follows:

SR2024-01 – Closed – Acceptable Action[6]

SR2024-02 – Closed – Acceptable Action

SR2024-03 – Open – Acceptable Response[7]

SR2024-04 – Open – Acceptable Response

SR2024-05 - Closed – Acceptable Action

[6] Closed – Acceptable Action – Response by recipient indicates action on the safety recommendation has been completed. The action complies with the safety recommendation

[7] Open – Acceptable Response – Response by recipient indicates a planned action that would comply with the safety recommendation when completed.