



THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

1999 JUN -7 PM 4:57

June 3, 1999

Ms. Elaine Kaplan
U.S. Office of Special Counsel
1730 M Street, N.W.
Washington, DC 20036-4505

Dear Ms. Kaplan:

Thank you for your letter (OSC File No. DI-97-0312) regarding allegations of violations of law, rule, or regulation by Messrs. David B. Johnson and Raul Trevino, employees of the Federal Aviation Administration's (FAA) Houston Air Route Traffic Control Center (ARTCC).

As requested by your office, the FAA conducted a thorough investigation of the allegations. Specifically, the Air Traffic Service Evaluations and Investigations Staff investigated the allegations that Messrs. Johnson and Trevino either ignored operational errors, failed to report operational errors based on redrawing of computer measurements of the National Track Analysis Program (NTAP) reports, or improperly classified operational errors as pilot deviations.

The investigation was conducted from January 27 through February 6. The manager of the Evaluations and Investigations Staff and the manager of the Investigations Division personally interviewed Messrs. Johnson and Trevino, and the manager of the Evaluations Branch personally interviewed the current manager of the ARTCC Quality Assurance Staff as well as 22 current and former personnel of that staff. In addition, the FAA conducted a technical review of the 301 immediate alerts, 52 pilot deviations, 7 operational error/deviation packages, and all facility Freedom of Information Act and Unsatisfactory Condition Report files. The 301 immediate alerts that were reviewed all occurred within the 15 days previous to the investigation.

The technical review was conducted in order to substantiate the current facility practices and thoroughness. The premise was that any improper application of procedures or

intentional distortion of findings or results would be detected by the technical review. However, the review found no evidence of misapplication of proper procedure and no evidence of data being incorrectly reported, misrepresented, or in any way altered to avoid reporting as required by FAA policies and regulations. As for the personnel interviews, both Messrs. Johnson and Trevino denied the allegations that they encouraged or condoned nonreporting or improper reporting of operational errors/deviations. Of the 22 past and current quality assurance personnel interviewed, only 3 indicated a belief that the allegations were substantially true. However, when asked to provide examples or specific instances where improper procedures were applied, or where there was a failure to report an operational error, none of the three were able to do so.

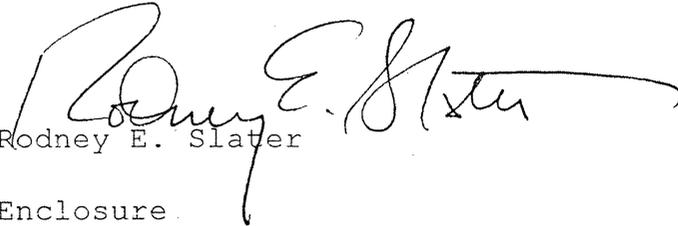
Specific inquiry was made into the five incidents cited as examples of wrongdoing. Those incidents allegedly occurred on October 12, 1996, December 30, 1997, July 15, 1998, August 21, 1998, and December 18, 1998. The inquiry was hampered by the fact that the only documentation available concerned the incident that occurred on July 15, 1998. Records of that incident were available because following an alert, the Memphis ARTCC determined that an operational error likely had occurred and that triggered a formal investigation. As a result, records were retained in order to facilitate the investigation. In none of the other instances was there a triggering event, and therefore the records were destroyed after 15 days in accordance with the records retention practices as set out in FAA Orders 1350.15B and 7210.3. Without the actual computer data to review, the investigation was limited to probing the recollections of those interviewed. Based on an assessment of the information gathered from the interviews, the allegations of unlawful practices were not substantiated.

On the assumption that the allegations of unlawful conduct were made in good faith, the only explanation the investigative team could offer concerns a fairly widespread misapplication of FAA Order 7210.56, paragraph 5-1-5, which provided allowances for interpreting data printouts. This process, informally known as "smoothing," allows for a tolerance of one fifth of a mile to be factored in the measurement of NTAP data to accommodate high-speed printer limitations.

In summary, the investigation did not reveal any violation, or apparent violation, of law, rule, or regulation. As a result of the investigation, we plan no further action.

If I can be of any further assistance, please let me know.

Sincerely,



Rodney E. Slater

Enclosure

January 29, 1999

STATEMENT

SUBJECT: Incident of July 15, 1998

On the evening of July 15, 1998, I was called at home by the Supervisory Traffic Management Coordinator (STMC) who was in charge of the evening shift at Houston ARTC Center (Houston Center). It was conveyed to me that Memphis ARTC Center (Memphis Center) had called the facility and advised that they had an Operational Error Detection Patch (OEDP) detection of less than standard separation on two flights and requested that we conduct a review.

Our investigation of the incident revealed that our computer had not detected less than standard separation (no OEDP indication) and that if an error had occurred it had happened on the boundary and had been caused by an action of the Memphis Center controller. Consequently, we called and advised Memphis Center that Houston Center had not had an error and that Memphis Center should report the incident if there was a loss of separation. Our NTAP data indicated that the aircraft had come close to losing separation, and both the STMC and myself felt more comfortable ensuring that the incident was reported, and then we could have the Houston Center Quality Assurance Office review the data in the morning. The issue was that we felt that a report should be made by the appropriate facility, which was Memphis Center.

After getting no cooperation from the Memphis Center watch supervisor, I telephoned Ron Franson, the Southwest Region Quality Assurance Staff Officer, and advised him of the situation. Mr. Franson conveyed to me that he had gotten in contact with his counterpart in the Southern Region, as well as with Washington headquarters, and it had been decided that the report could be delayed until the following day when both regions and facilities would discuss the issue. In the morning, a review of the Houston Center data indicated that no loss of separation had occurred. The information was conveyed to the Southwest Region Air Traffic Division, and the information was entered in the July 16, 1998, log.



Raul C. Treviño
Air Traffic Manager, Houston Center

January 29, 1999

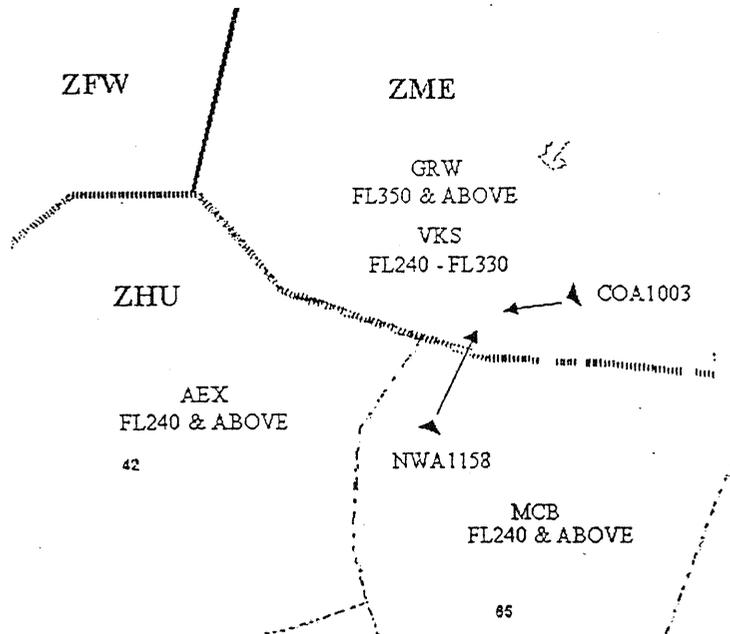
STATEMENT

On July 16, 1998, an occurrence was brought to the attention of this office involving COA1003 and NWA1158. To the best of our recollection this was an incident that happened in which the OEDP was activated in Memphis Center airspace. An investigation ensued once Memphis ARTCC called and advised Houston ARTCC. In the course of our investigation the following was discovered and was deemed a no-occurrence:

First, the OEDP was not activated in Houston Center's system, as a matter of fact NTAP's revealed that separation was never lost.

Secondly, the voice tapes revealed the controller at the Alexandria sector (AEX)* called the Vicksburg (VKS) sector in Memphis and pointed out COA1003 at FL350 and would be descending to FL310 to which the VKS controller approved. The AEX controller then called Greenwood High (GRW) in Memphis and requested COA1003 descending to FL310 and advised the GRW controller that the aircraft had been pointed out to VKS. At about this time the VKS controller was receiving a handoff from the McComb sector (MCB) on NWA1158 climbing to FL330. Although it was never verified with Memphis we believe the VKS controller thought it was the MCB sector that had pointed out COA1003.

*Description of airspace



Albert F. Webster
SMAP/QA

Deane Sweet
OAS

DDH
AEP/QA



U.S. Department of Transportation
Federal Aviation Administration

OFFICE OF SPECIAL COUNSEL
JUL 20 1999 10:49

July 20, 1999

Ms. Shirine Moazed
Office of Special Counsel
Attn: Disclosure Unit

Reference our telephone discussion yesterday morning, please find enclosed three copies of interview notes and explanations of analysis of NTAP data performed by my office. Please call me at (202) 267-9342 for clarification of acronyms and abbreviations or to answer any other questions you may have.

J. David Canoles
Manager, Air Traffic Evaluations
and Investigations Staff

OPTIONAL FORM 99 (7-99)

FAX TRANSMITTAL

of pages = 10

To <i>Shirine Moazed</i>	From <i>DAVE CANOLES</i>
Dept./Agency <i>Osc-Attn. Disclosure Unit</i>	Phone # <i>202 2679342</i>
Fax # <i>202-653-5151</i>	Fax #

NSN 7540-01-317-7368

5089-101

GENERAL SERVICES ADMINISTRATION

Review of Radar Data

"Incident 1" N593F/SCX1226 12/30/97

1. The limited photocopy of NTAP data is missing the date (UTC) and beacon assignments to correlate the depicted targets with the alleged aircraft,
2. The NTAP data does not appear to support the narrative, i.e., the westbound track of target B (alleged SCX1226) does not indicate a turn to heading 330 during the event (the depicted timeframe is too brief to validate the stated narrative).
3. Altitudes for westbound aircraft are handwritten so vertical separation can not be determined.

Validation of the incident requires a complete NTAP, voice rerecordings and flight progress strips, none of which were available.

"Incident 2" ASE483/UAL388 12/18/98

1. The limited photocopy of NTAP data is missing the date (UTC) and beacon assignments to correlate the depicted targets with the alleged aircraft,
2. The NTAP data does not clearly support the narrative, i.e., target B (assumed to be UAL388) indicates level flight at FL180, rather than a climb, for four of the five sweeps depicted.
3. An absence of a scale prevents accurate measurement of lateral separation.

The complainant states that, "The audio tape is key to determining that this error was concealed." Yet, a certified rerecording was not available with the package. Again, validation of the incident requires a complete NTAP with date, voice rerecording and flight progress strips, none of which were available.

"Incident 3" N900LE/N616DR 10/12/96

1. The limited photocopy of NTAP data is missing the date (UTC) and beacon assignments to correlate the depicted targets with the alleged aircraft,
2. The narrative states that the measurement from "the inside of target symbol A to the inside of target symbol B reveals separation was not maintained". NTAP measurements for the purpose of declaring operational errors are made from the centers of the targets. (FAAH 7210.56, Air Traffic Quality Assurance, dated 5/1/99, states in paragraph 5-1-5 d.1.(7) 1/5 mile is added to the distance between the printed symbol centers before making a determination. This was also the air traffic policy during October 1996.)
3. Most importantly, the plot size is not depicted on the photocopy to validate or invalidate the measurement. A plot size of 12NM is required (FAAH 7210.56, paragraph 5-1-5d.1.).
4. Depicted proximity indicates at least 5 miles required separation was maintained.

Review of Radar Data

There was no documentation or information available through interviews to validate that the incident was classified as a nonoccurrence due to target jump in a regional level review.

"Incident 4" COA1465/COA1970 8/21/98

The limited photocopy of NTAP data is missing the following necessary components:

1. plot size,
2. the date (UTC),
3. beacon assignments to correlate the depicted targets with the alleged aircraft (flight plan data necessary for validation)
4. An absence of a scale prevents accurate measurement of lateral separation.
5. Depicted proximity indicates at least 5 miles required separation was maintained.

Again, voice rerecordings, a complete NTAP printout and flight progress strips were needed to validate the allegation.

"Incident 5" NWA1158/COA1003 7/15/98

The limited photocopy of NTAP data is missing the following necessary components:

1. plot size,
2. the date (UTC),
3. beacon assignments to correlate the depicted targets with the alleged aircraft (flight plan data necessary for validation)
4. An absence of a scale prevents accurate measurement of lateral separation.
5. Depicted proximity indicates at least 5 miles required separation was maintained.

Again, voice rerecordings, a complete NTAP printout and flight progress strips were needed to validate the allegation. The information provided was inconclusive and was adequately explained in the statements of Paul Lynch, ZHU-500 and ASW-505.

The allegations made by the complainant are much too serious to be supported by documentation as limited as a partial photocopy of one item (radar data) of the many items (flight progress strips, voice rerecordings, personnel statements, etc.) required by FAAH 7210.56 for operational error investigation.

Jerry Cearley, DSR Training Coordinator

INTERVIEW

Each interviewee was advised that the purpose of the interview is to gather information pertaining to the ZHU investigation and reporting process for OE/OD's. They were advised prior to the interview of their right to representation and that their comments would be included in the investigation team's final report. The answers to the questions are not exact quotes, but are paraphrased from the team members' notes.

1. Have you been trained to modify your measurement of the computer-generated NTAP data? Specifically, were you told not to calculate the distance between the targets at their closest points?

Not specifically that way. We, all supervisors, were taught as a group how to be very flexible in measurement of target jumps. I told them at that time I disagreed with this. We had a special briefing (couple of years ago) about this. Scott Stoeckle did the briefing. Probably this direction came from Raul (Trevino). In the manner that we smoothed the probable track of the aircraft, for aircraft in turns we were instructed to measure away from the curves of the flight tracks in a straight line that showed separation was maintained.

2. When measuring NTAP data for the purpose of OE investigations, if only one sweep of the radar showed less than standard separation, were you trained to discount or ignore that data?

It was stated policy that we will have no "one hit" errors in the facility. Don't remember whether it was Bruce (Johnson) or Raul (Trevino), but probably Bruce (Johnson). Basically, one hit was not enough to show that we have a deal.

3. Are you aware of the re-drawing of flight paths as a technique utilized so as not to detect an error?

See answer to number one.

4. Have you been told to classify incidents that you believed were operational errors or deviations as non-occurrences because of target jumps?

Yes. We have problems with target jumps here. If it's appropriate, I don't have a problem. But I can't quote a specific example where I thought we had a deal and I was told to disregard it. If we have target jump, and we can use that in good conscience, we use it. It's not automatic to disregard an error because of target jump, but I've seen some very questionable, like the target jump occurred, then separation was lost. I am aware of a time like this, but can't give the specific example.

5. Have you been told to classify incidents that you believed were operational errors or deviations as pilot error?

Yes. I wasn't, but we had two departures north out of IAH up over LFK, and we wrote the pilot up for a deviation rather than accepting responsibility. But I didn't hear the tapes

Jerry Cearley, DSR Training Coordinator

myself. I was an STMC at that time. In this case the decision to make this a pilot deviation was made outside the control room. This was about a year or year and a half ago.

6. To your knowledge, has a regional-level review concluded that target jumps caused the loss of separation?

No, not aware of that.

7. Has any representative of facility management encouraged or ordered you to cover up an OE/OD?

Not directly, but it's been done above my level. The decision was made above my level and I disagreed with it and voiced it. I have a FOIA in on this. We drove an aircraft into LRD without a handoff. I called it in, but it was determined to be a non-occurrence. I met with Raul (Trevino) and Joan (Mallen) about it and told them we were damaging the credibility of the facility and we derogate the system. They said it was reclassified with the concurrence of the regional office. I showed ASW-505 all of this during the OE investigation. ZHU-C-96-D-001, occurred on 1/23/96, and was reclassified. Don't remember the justification, but think it was that LRD had a flight plan and knew the aircraft was coming. Also talked to Doug Murphy about the concerns with OE reporting on 2/26/97.

8. If yes, who was it and what were the circumstances?

See answer to number seven.

9. What followup does the QA Office do on the OEDP summaries?

When we get an alert, the WS calls the specialty and asks about the circumstances. The supe tells the situation. If necessary, we do a preliminary investigation. The WS has the MAC do the NTAP and DART, and pull the tape. The OS makes the determination. The WS ramrods the process to make sure the time limits are met, but the call is made by the OS.

Don't know what kind of alert review is done now. When I was in QA we randomly selected and reviewed the summaries. We found some problems then.

10. Do you know of anyone else we need to talk to about this or do you have any other documentation to assist us in this? Are you aware of any incidents on file at this facility we need to look at?

No. Not that I know of except what's in the facility under FOIA.

I expect some form of retaliation for my participation in this effort. We're not lying. Most of us have facts to back it up.

Jerry Cearley, DSR Training Coordinator

11. Via telephone on 1/29/99, the investigation team asked Mr. Cearley for the "facts" referred to in the above comment.

The documentation I have is on file in the Freedom of Information Act (FOIA) requests retained at ZHU.

Carl Reed, Operations Supervisor

INTERVIEW

Each interviewee was advised that the purpose of the interview is to gather information pertaining to the ZHU investigation and reporting process for OE/OD's. They were advised prior to the interview of their right to representation and that their comments would be included in the investigation team's final report. The answers to the questions are not exact quotes, but are paraphrased from the team members' notes.

1. Have you been trained to modify your measurement of the computer-generated NTAP data? Specifically, were you told not to calculate the distance between the targets at their closest points?

We've had training at supervisor's meetings where it was implied at least to ignore that data. Somewhere around the spring of 96. Training done by (Scott) Stoeckle.

2. When measuring NTAP data for the purpose of OE investigations, if only one sweep of the radar showed less than standard separation, were you trained to discount or ignore that data?

Whatever that NTAP reflects, if you have one hit where there was less, we were specifically told that would not constitute a loss of separation.

3. Are you aware of the re-drawing of flight paths as a technique utilized so as not to detect an error? If so, who? Any specific incidents on file?

I can say that I've seen that. I won't say who because I'm concerned about retaliation for my participation in this. Jerry Thomas has done several of these. They've used him because he's trained in QA. I don't personally have any documentation to support this.

4. Have you been told to classify incidents that you believed were operational errors or deviations as non-occurrences because of target jumps?

I have not been told. Again this is implied.

5. Have you been told to classify incidents that you believed were operational errors or deviations as pilot error? Who?

Again, I have not been told that specifically, but I have witnessed that. I'm aware of two incidents in my area (LFK) in December 97. Can't give specifics, just remember the time. I guess QA made the determination. It went up as an error and came back as a pilot deviation, but I've no knowledge of who was involved in the process.

6. To your knowledge, has a regional-level review concluded that target jumps caused the loss of separation?

I've been told of one. He was very specific about it. Jeff Kenworthy is his name. He's a controller and he was involved.

Carl Reed, Operations Supervisor

7. Has any representative of facility management encouraged or ordered you to cover up an OE/OD?

Not me personally. Certainly others I know of have been encouraged to do this.

8. If yes, who was it and what were the circumstances?

Paul Lynch was encouraged by Raul Trevino in July 98. Around the 15th or 16th.

9. Who do you feel will retaliate against you?

Senior facility management up to and including regional management (Doug Murphy).

Diane Boyd, Supervisory Traffic Management Coordinator

INTERVIEW

Each interviewee was advised that the purpose of the interview is to gather information pertaining to the ZHU investigation and reporting process for OE/OD's. They were advised prior to the interview of their right to representation and that their comments would be included in the investigation team's final report. The answers to the questions are not exact quotes, but are paraphrased from the team members' notes.

1. Have you been trained to modify your measurement of the computer-generated NTAP data? Specifically, were you told not to calculate the distance between the targets at their closest points?

Yes. We've had some training by a QA specialist showing us how to measure to allow for target jump. The specialist was Scott Stoeckle. I don't mind talking, but I'm afraid of what might happen to me (retaliation). I believe we have taken liberty with rules. I spent two and a half years as a QA specialist. Don't know who directed Scott to provide that training.

NOTE: When Ms. Boyd expressed concern about retaliation, Mr. Romero strongly urged her to take some time to consider whether or not she wished to speak to the investigation team and reiterated that her comments would become a part of the final report. Ms. Boyd considered this and said she would like to hear the questions and answer them as she felt comfortable.

2. When measuring NTAP data for the purpose of OE investigations, if only one sweep of the radar showed less than standard separation, were you trained to discount or ignore that data?

Yes. Bruce Johnson's words before a group of people were, we will not have any one-hit errors in this facility. Can't answer if this is supported by current manager. Have not recently encountered an error that received one hit on the NTAP. The STMC's are not actively involved in OE determination. We obtain the data for the supervisors who make the call with support from QA.

3. Are you aware of the re-drawing of flight paths as a technique utilized so as not to detect an error?

Yes. Cited incident with two aircraft off New Orleans whose flight paths were modified by Bruce Johnson and Raul Trevino based on the headings the aircraft were assigned.

4. Have you been told to classify incidents that you believed were operational errors or deviations as non-occurrences because of target jumps?

Target jump is misapplied. There are lines drawn that I don't know where they come from. Most supervisors don't know how to read the NTAP, but there are people in the facility with experience who interpret the data in ways I don't understand.

5. Have you been told to classify incidents that you believed were operational errors or deviations as pilot error?

Diane Boyd, Supervisory Traffic Management Coordinator

Yes. I can't give specifics as to when the last one was. This has happened on more than one occasion. Sometimes QA initiates this, normally someone outside the control room makes this determination and tells us.

6. To your knowledge, has a regional-level review concluded that target jumps caused the loss of separation?

First hand knowledge, no.

7. Has any representative of facility management encouraged or ordered you to cover up an OE/OD?

No, but they would not do that. They would tell me that a determination has been made and tell me what it is. As I said, I've seen things I thought were errors be classified as something else, but I haven't seen the process how this happens.

8. Have you brought your concerns forward within the facility?

Yes, but not to the region. I had actually come to the conclusion that whatever was going on had become a national policy. Did not talk to ASW-505 during the OE investigation in November.

9. What followup does the QA Office do on the OEDP summaries?

Unless it's something obvious, like the aircraft working approach control and the minimum separation is more than three miles, or MARSAs - if there's any question about what's going on, we call the supervisor to check on it. Sometimes when they're using visual, they alert us to expect an OEDP alert. Have no knowledge of further review, but if we miss one, which happens rarely, then QA comes back and tells us that we missed it. I think QA looks to see that they were all addressed, but not aware of any validation.



U.S. Department
of Transportation
**Federal Aviation
Administration**

Director of Air Traffic

800 Independence Ave, SW
Washington, DC 20591

FEB 9 2000

The Honorable Elaine Kaplan
The Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW., Suite 300
Washington, DC 20036-4505

Re: OSC File No. DI-97-0312

Dear Ms. Kaplan:

Please let this serve as confirmation of the actions the Federal Aviation Administration (FAA) will be taking in the referenced matter. As you will recall, the FAA's Air Traffic Service Evaluations and Investigations Staff conducted a thorough investigation into the allegations regarding the nonreporting of operational errors at the Houston Air Route Traffic Control Center (Houston Center). Subsequent to the investigation, representatives from the FAA's Evaluations and Investigations Staff and the Office of the Chief Counsel have provided information and have had discussions with members of your staff. This letter confirms that the FAA will take the additional steps listed below to address the concerns raised by the allegations.

1. By February 15, I will issue, in my capacity as the Director of Air Traffic, a policy statement to all air traffic employees nationwide reiterating the importance of reporting all operational errors, without exception.

2. Since January 18, the Air Traffic Manager of the Houston Center has been personally conducting training for all Houston Center employees to ensure they are aware of the requirement to report all operational errors, without exception. This training will be recorded in each employee's training record and is expected to be completed by March 1.

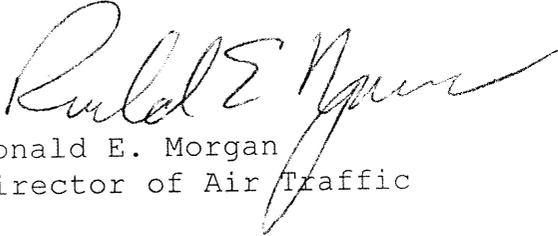
3. The Air Traffic Investigations Division is developing a new training module for the agency's Quality Assurance Course that trains persons on the National Track Analysis Program (NTAP). This training will be mandatory for all persons using the NTAP data and will ensure the uniform measurement of NTAP data. We expect development of the training module to be completed by May 1. Once the module is completed, it will take approximately 4-6 months for all individuals using the NTAP data to be trained.

I trust that these actions address the concerns that have been raised by the allegations.

If you have any further questions regarding this matter, call Jerry Mellody, Assistant Chief Counsel for Personnel and Labor Law, Office of the Chief Counsel, on 202-366-4099.

Thank you for your efforts to resolve the allegations.

Sincerely,



Ronald E. Morgan
Director of Air Traffic

August 15, 1999

Dear Ms. Shirine Moazed,

This correspondence is in response to the Report of the Secretary of Transportation reference OSC File No. DI-97-0312 and dated June 3, 1999 and received by me on August 9, 1999.

With all due respect to the honorable Secretary, I can only characterize and summarize this report as misleading and in fact, untruthful. This is substantiated by the fact that although there is an admission of "a fairly widespread misapplication of FAA Order 7210.56, paragraph 5-1-5" the report tends to obscure the fact that this "misapplication" is intentional. The report attempts to explain away this "misapplication" as "allowances for interpreting data printouts."

I respectfully submit that this "misapplication" was intentional and intended to conceal operational errors at Houston ARTCC. Why would the FAA rely on data that could be considered unreliable, misinterpreted, or misapplied? I would like to point out this type of data was relied upon to determine the location of J.F. Kennedy Jr.'s downed aircraft.

The information I provided was from information directly obtained from the Quality Assurance office at Houston ARTCC. The Report cites various dates that "Specific inquiry was made into five incidents." Two dates were wrongly identified in their report. There is reference to the dates of December 18, 1998 and July 16, 1998. The report also states "In none of the instances.....therefore the records were destroyed after 15 days in accordance with...Orders 1350.15B and 7210.3." There can be no denial of the fact that these records were available. Several instances were cited in which the loss of separation was determined to be pilot deviations. As required by Orders 1350.15B and 7210.3 these records are required to be retained for a period of two and one half years.

My original submission of evidence included certified rerecordings of several questionable rulings by the Quality Assurance staff at Houston ARTCC. Included in the report was information provided by J. David Canoles. The information from Mr. Canoles states that "validation of the incident requires a complete NTAP, voice rerecordings and flight progress strips, none of which were available."

This investigation was tainted from the outset. This is substantiated by the fact that, although I provided adequate evidence, the investigators chose to disregard it. This is further substantiated by the fact all of the information was readily available (NTAP, voice rerecordings, and flight progress strips) in the Quality Assurance office at Houston ARTCC.

As previously stated, once an 'event' is determined to be an 'incident', such as a pilot deviation, all records are required to be retained for 2 1/2 years. It is significant to note that pilot deviations do not reflect on the operational error record of the facility, but record retention is still required.

To further substantiate the fact that an unbiased investigation was not conducted, the report alludes to the fact that "Memphis ARTCC determined that an operational error likely had occurred and that triggered a formal investigation." As a result, records were retained in order to facilitate the investigation." Houston ARTCC destroyed it's records. Memphis ARTCC felt compelled to retain it's records while Houston ARTCC chose to destroy their records. I can assure you that although two commercial airliners came within close proximity of each other, a proper investigation was not conducted. This is evidenced by the statements provided by Mr. Trevino, Air Traffic Manager at Houston ARTCC and the Quality Assurance staff.

In Mr. Trevino's statement he states, "the issue was that we felt that a report should be made by the appropriate facility, which was Memphis Center." In short, an incident had occurred but we (Houston) are not going to report it. "After getting no cooperation from the Memphis Center watch supervisor, I telephoned Ron

Franson, the Southwest Region Quality Assurance Staff Officer, and advised him of the situation."

It is apparent that a determination was subsequently made by a higher authority that Houston ARTCC should make the report as it was their error. This is substantiated by the fact that Mr. Trevino's statement concludes in this manner, "In the morning, a review of the Houston Center data *indicated no loss of separation had occurred.*" The information was conveyed to the Southwest Region Air Traffic Division, and the information was entered in the July 16, 1998, log."

Statements by the Q.A. staff revealed the following: "Although it was never verified with Memphis we believe the VKS controller thought it was..." An investigation was supposedly conducted and the conclusion was that an error had not occurred based on unverified information. By the manner in which the statement is written it is apparent that the Houston Q. A. office wanted to give the appearance that it was an error by Memphis ARTCC but yet they (Houston) assert the claim that separation was never lost. In short, two airliners came within close proximity of each other and to give the appearance of effective management, it does not get properly investigated or reported.

The information provided by J. David Canoles identifies the Agency's motivation to conduct a tainted investigation. "The allegations made by the complainant are *much too serious* to be supported by documentation as limited as a partial photocopy of one item (radar data) of the many items (flight progress strips, voice recordings, personnel statements, etc.) required by FAAH 7210.56 for operational error investigation. With all due respect for Mr. Canoles' view on these matters, the purpose of the Agency's investigation was to investigate the concealment of operational errors not to investigate operational errors.

The report states "Of the 22 past and current quality assurance personnel interviewed, only 3 indicated a belief that the allegations were substantially true." What the report fails to state is that all three of these individuals had a number of years of experience interpreting this data. One individual was the former Manager for

Quality Assurance for more than four years and the other two had been specialists specifically trained in the investigation of operational errors.

To further substantiate that this investigation was tainted, the report states "However, when asked to provide *examples or specific instances* where improper procedures were applied, or where there was failure to report an operational error, none of the three were able to do so." Examples and specific instances were in fact identified in statements provided by personnel. This is evidenced by the fact that the July 15, 1998 incident provided a required response from Mr. Trevino and the Q.A. staff.

In conclusion I maintain that a proper and unbiased investigation into this matter was not conducted. I submit that an objective, unbiased, and dispassionate review of the original evidence provided would result in another outcome. My recent experience regarding the concealment of operational errors at Houston ARTCC substantiates the fact that this practice has continued.

Sincerely,