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**Analysis of Disclosures, Agency Investigation and Report, Whistleblower Comments, and
Comments of the Special Counsel**

Summary—OSC File No. DI-04-1232

The whistleblower in this case, Anne R. Whiteman, an employee at Dallas Fort Worth International Airport (DFW) for 20 years and an air traffic controller for 18, alleged that air traffic controllers and management personnel at the DFW Terminal Radar Approach Control (TRACON) routinely covered up serious operational errors and deviations involving aircraft. She stated that incidents of aircraft flying too close to each other, occur, on average, once a month and that many of these incidents are neither reported nor investigated. She alleged the failure to report and investigate potential operational errors was a violation of Federal Aviation Administration (FAA) Order 7210.56C, *Air Traffic Quality Assurance*, and a substantial and specific danger to public safety. The Department of Transportation Office of Inspector General (DOT OIG) substantiated Ms. Whiteman's allegations finding that air traffic controllers and management systematically covered up operational errors.¹ The DOT OIG's investigation revealed an improper management practice in place for seven years was responsible for underreporting and the failure to investigate operational errors.

The Whistleblower's Disclosures

Ms. Whiteman alleged that for at least two years, FAA employees at the DFW TRACON routinely failed to report and investigate serious operational errors jeopardizing the airport and air traffic safety. In some instances the supervisors on duty declined to conduct the required investigation by failing to review the radar data and flight data plots, and by failing to interview the air traffic controllers and, where necessary, the pilots involved. In other instances, she alleged that the Air Traffic Manager (ATM) failed to notify FAA Headquarters (Headquarters) of errors. Ms. Whiteman alleged that serious operational errors involving aircraft flying dangerously close to one another occur, on average, at least once a month at DFW. Many of these incidents were neither reported nor investigated. Ms. Whiteman also alleged that since FAA instituted an award program in 2002, former ATM Ross Schulke, the current ATM JoEllen Casilio, and several supervisors within the facility failed to conduct proper initial investigations or notify headquarters of operational errors and/or deviations.

Ms. Whiteman contended that the failure to report and investigate operational errors as described above constituted a violation of FAA Order 7210.56C. She described two incidents which should have been reported and provided two sets of plots reflecting operational errors. The first shows two aircraft converging as they approach the runway and one aircraft enters the

¹ The report notes that an operational deviation occurs when an aircraft controlled by one controller enters the airspace of an aircraft controlled by another controller without proper coordination. In DOT's report the term operational errors includes operational deviations.

airspace of another without coordination. The radar data reflect a loss of separation between the two aircraft showing that at one point they were only 300 feet and .53 miles apart, well below the minimum separation of 1,000 feet or 3 miles for aircraft within 40 miles of the airport.

Mr. Schulke² did not report this incident because he stated there were incomplete data. While Ms. Whiteman acknowledged a break in the data, she explained that such breaks occasionally occur during loss of separation because the computer equipment has difficulty distinguishing between the two aircraft. She also stated that the recording resumed within a few seconds and showed a serious loss of separation thereafter. She maintains that Mr. Schulke was required to report this operational error to Headquarters.

In the second example, another air traffic controller, Jeff Frye, allowed his aircraft to enter the airspace of Ms. Whiteman's aircraft without prior approval or coordination, thus committing an operational deviation. The radar data indicated that a loss of separation occurred and that at one point the aircraft were only 1.69 miles and 900 feet apart. Ms. Whiteman stated that Mr. Frye willfully ignored her repeated requests to correct the loss of separation and that he took action only after being ordered to do so by a supervisor, Marisa Blackwell. According to Ms. Whiteman, neither Ms. Blackwell, nor Acting ATM Pat Smith conducted an investigation or reported the deviation to Headquarters.

In July 2002, Ms. Whiteman reported the failure to investigate and report operational errors to the DOT OIG. She stated that FAA's Security and Compliance Office conducted an investigation in March 2003. In October 2003, she was informed by Ms. Casilio and former Southwest Region Administrator Doug Murphy, that the investigation did not reveal any wrongdoing. Ms. Whiteman maintained that Ms. Casilio and other supervisors still did not properly investigate or report serious operational errors.

Finally, Ms. Whiteman noted a more recent incident which occurred on February 29, 2004. This incident involved a loss of separation between two aircraft resulting in an operational error. She stated that a Quality Assurance Review was prepared to reflect a preliminary investigation of the incident but the TRACON personnel did not report it to Headquarters. She emphasized that because serious errors are not reported to Headquarters they are never properly reviewed by Headquarters. As a result, TRACON employees continue to compromise air safety.

The Report of the Department of Transportation

The report validates Ms. Whiteman's allegations regarding cover-ups and concludes that her whistleblowing and the subsequent investigation exposed a management practice in place at the DFW TRACON for seven years which improperly investigated and, therefore, underreported operational errors. The DOT OIG concluded that the cover-ups, whether due to management policy or on an incidental basis, represent safety deficiencies and undermine the public's confidence in the air traffic control system.

² Mr. Schulke retired in January 2003.

FAA policy on the investigation and reporting of suspected operational errors is set forth in FAA Order 7210.56C, *Air Traffic Quality Assurance*. Under the Order, employees who are aware of potential errors are to report them to the supervisor or controller-in-charge for investigation. The use of playback tools is authorized to assist in the investigation of the suspected errors by recreating the incident in question.³ FAA officials interviewed about the Order and its application insisted that it requires review of playback data to investigate suspected operational errors. The OIG found, however, that the language of the Order was ambiguous on that issue.

The OIG conducted the investigation into these allegations with technical assistance from FAA's Air Traffic Office of Safety Evaluations. The investigation included interviews with Ms. Whiteman; controllers and supervisors, including those involved in unreported operational errors; the use of playback tools, software programs and other electronic instruments used to recreate air traffic incidents to analyze radar and voice recordings for air traffic operations; and interviews of current and former TRACON managers and quality assurance personnel.

According to the report, in 1996, Mr. Schulke, implemented a local policy which ran counter to FAA-wide policy. The report found that the local policy inhibited the appropriate use of playback tools. Instead of using the technology available to conduct an investigation, the report found that the DFW TRACON relied on the word of the controllers to establish whether or not an error occurred. The report characterized the system used by the DFW TRACON to resolve operational errors as an honor system. Under this system, investigation of suspected operational errors was limited to asking the controller involved whether separation had been lost. If the controller responded in the negative, no further inquiry was undertaken. Only if the controller acknowledged that separation was, or may have been lost, were the playback tools employed to determine whether an operational error had occurred.

This local policy resulted in significant underreporting. In the first 6 months of 2004, prior to the DOT OIG's investigation, DFW TRACON reported 2 operational errors. After correct implementation of the playback tools, the DOT OIG confirmed 36 operational errors during the next 6 month period. The report notes that 28 of those errors were classified as moderate severity.⁴ The investigation also substantiated both incidents Ms. Whiteman included in her disclosure were operational errors, one of moderate severity and the other as low severity. To ensure that no other facilities have misinterpreted the Order, FAA's Air Traffic Office of Safety Evaluations reviewed other TRACONs and concluded that the DFW TRACON's policy on operational errors was an anomaly.

The OIG identified several factors which contributed to DFW's failure to investigate suspected operational errors. Mr. Schulke issued a verbal order instructing that operational errors were only to be investigated after the controller acknowledged a loss of separation and

³ The tools allow the replay of recorded voice and radar data to review air traffic incidents suspected of being operational errors.

⁴ The report specifies that under FAA policy operational errors are classified as low, moderate or high severity. The level of classification is based on an index which assigns a point value according to a number of factors, including but not limited to, the proximity of the aircraft and their flight paths.

only then were playback tools to be used. He later memorialized that instruction in a written directive issued in October 2000. When questioned about the policy and his management and investigation of operational errors, Mr. Schulke gave contradictory statements but stated his belief that the policy was the result of an agreement with the National Air Traffic Controllers Association (NATCA). The investigation found no such agreement but found that many employees felt Mr. Schulke discouraged the reporting of operational errors.

The OIG also found that there were missed opportunities to detect and remedy the TRACON's improper investigative policy. In July and October 2002, Ms. Whiteman contacted the FAA Administrator and the OIG hotlines alleging unreported operational errors at the facility and identified three specific incidents. The allegations were investigated by FAA's Headquarters Air Traffic Office of Safety Evaluations, and two of the three incidents were substantiated as operational errors. However, the incidents were reviewed as separate and discreet events and the facility's improper management policy was not discovered.

Additional factors identified were the lack of oversight by the TRACON's quality assurance unit and inefficient oversight by Ms. Casilio. David Slaton, Quality Assurance Manager until recently, advised the investigators that once the quality assurance personnel became NATCA members, FAA was required to pay them overtime to conduct reviews of suspected operational errors. Mr. Schulke did not want to pay overtime and, instead, directed that only supervisors investigate suspected operational errors.

Ms. Casilio became the manager of the DFW TRACON in October 2003. During her interview she maintained that she was unaware of the restriction on the use of playback tools. She also stated that she had not focused on the low incidence of reported errors. When confronted with the investigation's findings, Ms. Casilio felt responsible for not providing adequate oversight. To correct the local misinterpretation of the Order, she issued a policy memorandum to her staff on June 25, 2004, directing the immediate use of playback tools to investigate all suspected operational errors.

The OIG also cited ambiguity in the wording of FAA Order 7210.56C as a contributing factor to the underreporting. The investigation concluded that the Order was subject to multiple interpretations, thus, allowing for the possibility that use of playback tools was optional in the investigation of a suspected operational error.

Finally, the OIG concluded that the incentive program in place at DFW from January 2002 to January 2003, was not a factor in the underreporting. Under the program, initiated on a trial basis by FAA's Southwest Region Air Traffic Division, all controllers would receive 4 hours of time off if the facility was error-free for 90 days. In June 2002, one award was given to DFW TRACON controllers. The program was discontinued after a one-year test period because the goal of 90 days error-free was found to be unrealistic.

OIG Audit

In September 2004, the DOT OIG completed its nationwide audit of controls on the reporting of operational errors. The issue of controllers self-reporting errors has been described as one of its biggest management challenges. FAA still heavily relies on self-reporting for the identification of operational errors. Only 20 of FAA's 524 air traffic control facilities have automated systems which identify errors; and those 20 are en route facilities which handle approximately one quarter of the traffic managed by TRACONS. The inadequacy of self-reporting as a tool for capturing these errors is demonstrated by the error rates reported by the two types of facilities in the audit. In 2003, 684 errors were reported by en route facilities compared with 501 errors reported at all 504 TRACONS.

In response to its audit, the DOT OIG made recommendations to FAA on ways to improve the identification and reporting of operational errors. Specifically, the OIG recommended using playback tools to conduct random audits of radar and voice data instead of limiting their use to the investigation of suspected errors. The OIG also recommended that quality assurance staff be required to periodically review voice and radar data to evaluate whether operational errors are being reported. Finally, the OIG recommended that FAA's Air Traffic Office of Safety Evaluations be required to review and test audit records at TRACON facilities as an oversight measure to ensure the quality assurance personnel are conducting periodic audits of the playback data.

FAA concurred with the recommendations and commissioned a work group to develop a plan for their implementation. On March 11, 2005, FAA provided an update on the implementation of these recommendations stating that current orders allow the use of playback tools to identify operational errors, radar replay and voice files will be used to conduct random audits of air traffic services and air traffic evaluation staff will review records at TRACON facilities to ensure that random audits are being conducted. The language of FAA Order 7110.10, *Air Traffic Safety Evaluation Order*, will be changed to reflect the new requirement. The update is included as Appendix C to the report.

Corrective Actions Taken at DFW

As noted previously, the errant DFW policy has been rescinded and replaced by a new policy issued on June 25, 2004, which orders the use of playback tools to investigate all suspected operational errors. In addition, the DFW facility has been placed in a "no notice review" status for 2 years. During this time period evaluations staff can come to the facility unannounced to determine whether operational errors are being accurately reported.

A number of personnel actions were taken in response to these investigative findings. In addition to the information provided in its report, DOT OIG provided an update on disciplinary action which is included as Appendix D. FAA reassigned the facility quality assurance manager and selected a replacement. The facility manager, operations managers and supervisors were placed on Opportunity to Demonstrate Performance (ODP) status for failing to abide by FAA national policy for the investigating and reporting of operational errors, individual controllers were given training for operational errors and placed on ODPs for failing to self-report errors,

and one controller was decertified for committing a previously unreported operational error. Additionally, DFW was added to the inspection schedule of the new Air Traffic Safety Oversight Service (AOV) which is charged with ensuring the safety of changes to air traffic standards and procedures. AOV conducted a safety compliance audit of DFW on June 6-10, 2005 and gave DFW a very positive review.

Finally, in response to additional requests from OSC, the DOT OIG conducted more in-depth analysis into the examples of loss of separation provided in the report. That analysis concluded that even though each incident represented a loss of separation, they were not examples of near mid-air collisions. The additional analysis is included as Appendix E to DOT's report.

The Whistleblower's Comments

Ms. Whiteman is grateful for the investigation and that the allegations regarding the intentional cover-up of operational errors were substantiated. However, she also commented that the report failed to address the issue of reckless conduct by controllers which endangered aircraft. Additionally, she remains deeply troubled by the management and operation of DFW TRACON. She submitted detailed comments, with supporting documentation, only briefly summarized here. In those comments, she describes areas where she believes the investigation was lacking and highlights areas of continued concern. She describes the hostility she endured in the work place and continues to question why FAA management condoned the harassment and workplace violence she has repeatedly reported over the past seven years.

Ms. Whiteman believes that the credibility of the investigation suffers because the blame is placed on Mr. Schulke's prohibition on the use of playback tools. Describing supervisor misconduct, Ms. Whiteman states that Mr. Schulke was only partially responsible for the cover ups. She commented that some supervisors simply choose not to report errors while others laughed at them. Ms. Whiteman states that the same policy was in place under Ms. Casilio, prior to Mr. Schulke, yet the report does not hold her accountable. In addition, Ms. Whiteman believes the issue of covering up operational errors is trivialized by emphasizing the problems with self-reporting and not really addressing the intentional, recklessness and game playing conduct she reported. Another factor that compromised the investigation according to Ms. Whiteman was that controllers were interviewed with additional personnel present, and that thus, they were not free to speak freely.⁵

Given the potential for catastrophic consequences—loss of aircraft, life as well as great monetary loss, resulting from operational errors, Ms. Whiteman does not believe that putting individuals on ODPs is sufficient disciplinary action. She is concerned that individuals will not view the punishment seriously and will not change their behavior in response to the investigation. In order to address the relevant safety issues and successfully combat the problems faced by DFW TRACON, she believes the culture of the agency needs to change and individuals, including management officials, must be held accountable for their actions.

⁵ In response to this point, DOT OIG stated that controllers were permitted to have union representatives with them if they chose to, but that no management personnel were present for the interviews.

Similarly, she notes that retraining will not be sufficient to combat this problem because the individuals know the procedures but intentionally flout them. Again, she notes the need for accountability at all levels and a review of the intentional reckless conduct perpetrated by some controllers and allowed by management. Finally, she believes that keeping the same management officials at the top will prevent any real change from occurring.

Conclusion

Based on the representations made in the agency report and as stated above, I have determined that the agency report contains all of the information required by statute and that its findings appear to be reasonable.