THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

August 13, 2008

The Honorable Scott J. Bloch
Special Counsel
U.S. Office of Special Counsel
1730 M Street N.W., Suite 218
Washington, DC 20036

Re: OSC File Nos. DI-06-1499; DI-07-2156; DI-07-0237

Dear Mr. Bloch:

Thank you for your letter of July 22, 2008, concerning the status of corrective disciplinary and programmatic actions at the Federal Aviation Administration's (FAA) Dallas-Fort Worth (DFW) Terminal Radar Approach Control (TRACON) facility. Your inquiry arises out of the Office of Inspector General's (OIG) investigation of serious safety-related disclosures which you referred to me in July 2007, and my April 24, 2008 response to you. The disclosures, which the OIG substantiated, alleged that DFW TRACON management misclassified and underreported controller operational errors/deviations.

The OIG investigative report contained a number of recommendations to preclude the recurrence of underreported operational errors at DFW TRACON. These recommendations included permanent changes in DFW TRACON management and consideration of appropriate administrative action for the seven TRACON managers who bear responsibility for this serious matter, as well as significant programmatic corrective actions. As you noted in your letter, in an April 16, 2008 memorandum, Acting Administrator Sturgell accepted the OIG findings and reported that FAA had already taken, or was in the process of taking, administrative and programmatic actions to ensure there is no recurrence of underreported operational errors. The Acting Administrator has provided me regular reports on the status of FAA's corrective actions in this matter. As described below, FAA has made significant progress in addressing the OIG recommendations as well as other actions that the FAA independently identified.

In January 2008, both senior DFW TRACON officials, the Manager and Assistant Manager, were removed from the facility and interim leadership was immediately installed. The FAA has since proposed administrative action against all seven TRACON managers who bear responsibility for the misclassification of operational errors/deviations. These actions include suspension; demotion to non-supervisory, non-safety, support positions; reassignment; written reprimand; and retraining. Please note that the OIG has briefed Office of Special Counsel staff on specifics of these administrative actions.

The FAA is also in the process of reviewing the role and responsibility of several headquarters managers cited in the OIG report with regard to the underreporting of operational

errors/deviations. The FAA expects to complete its review before the end of August, and I will advise you of the results.

In addition to recommendations concerning disciplinary actions, the OIG made several recommendations concerning strengthening oversight and procedures. The FAA has taken significant steps to implement these recommendations as outlined below.

The OIG recommended that FAA's Air Traffic Safety Oversight Service (AOV) conduct comprehensive, on-site, "no-notice" audits at DFW TRACON. In April, the AOV began monthly "no notice" audits. The results indicate a significant improvement in the facility's reporting procedures and there were no issues identified during the June audit. AOV recently noted that the Acting Manager of the facility has implemented procedural changes for reviewing operational events to address previously identified weaknesses. In addition to the AOV audits, ATO Safety maintains a monitoring presence at the facility.

The OIG recommended an expedited deployment of Traffic Analysis Review Program (TARP). The FAA is accelerating the implementation of TARP at DFW TRACON that detects losses of separation by the end of Fiscal Year 2008, instead of 2011 as initially planned. Accelerated nationwide deployment will be completed by the end of 2009.

The OIG recommended the removal of the Quality Assurance function at all Air Traffic Control facilities from the supervision of the facility. The FAA is transferring the Quality Assurance function from the air traffic control facilities to the Air Traffic Organization (ATO) Services Area, establishing an independent quality assurance function that is responsible for reporting to the Vice President for Safety. This will change the current event reporting process, transferring responsibility for event determination from the facility manager to this independent office for safety assurance. While the quality assurance responsibility transfers to ATO Safety in the Service Area, FAA will continue to retain a quality control function in the facilities to ensure compliance with safety rules and regulations. In addition, to provide proper oversight, ATO Safety is formalizing the review of facility reporting through quarterly reports to the ATO's Chief Operating Officer (COO) and AOV beginning in October. The Vice President for Safety is accountable for these quarterly reports and AOV will conduct an independent validation of ATO Safety audit results and report quarterly to the Acting Administrator and the COO.

The OIG recommended a "top-to-bottom" review of ATO Safety's management, staffing, and processes. To address the policy and procedural issues that surfaced during the OIG investigation, the ATO's new Vice President for Safety is conducting a top-to-bottom review of the safety organization and functions within the ATO. This review will soon be complete and organizational changes will be made to strengthen the investigation/audit responsibilities. The FAA expects to have all of the organizational changes fully functioning by the end of the year.

The OIG recommended the consideration of training for certain DFW and Dallas Love Field Flight Standard District Office officials. The FAA is taking action beyond what the OIG recommended. In addition to training for certain DFW and Dallas Love Field Flight Standard District Office officials, training for the entire inspector workforce will be completed during the week of August 25, 2008.

The OIG recommended that all 38 TRACON-declared pilot deviations be examined, invalid pilot deviations rescinded, and pilot records expunged. Flight Standards will complete its review of the events that were misclassified as pilot deviations to ensure that no pilot was adversely impacted as a result. An initial review indicates that a limited number of cases may not have been handled properly. All 38 reports identified by the OIG will be reviewed and any follow-up actions with the affected pilots will be completed by the end of August.

The OIG recommended the reconsideration of DFW as FAA's "Central Region Large TRACON Facility of the Year." FAA rescinded the award in April and the plaque commemorating the award was returned by the facility.

In addition to implementing the OIG's recommendations, the FAA is taking a number of actions to address safety oversight issues.

- The FAA is assessing the creation of an internal Oversight Office that is independent of the lines of business.
- The FAA is developing a process for analyzing hotline and whistleblower complaints to identify trends and appropriate follow-up actions.
- The FAA began implementation of a voluntary safety reporting program at its Chicago-area facilities and plans to implement the program at the DFW facilities by October 31, 2008.
- The FAA has placed a renewed focus on training and reinforcement of safety reporting procedures and intends to conduct safety training for the ATO facility managers and safety officials in Washington, DC, August 19-21, 2008. This training will include a module on roles and responsibilities for reporting safety incidents.

The FAA has undertaken significant internal corrections and changes to address the misclassification and underreporting of operational errors or any other issues that could adversely impact safety at DFW TRACON. An initial review was conducted by AOV last year, and on October 15, 2007, they reported to the OIG that the misclassification and underreporting of operational errors appear to be isolated to this facility, and not systemic. The OIG is also exploring this issue, and noted in its April report that it had initiated an audit in November 2007 to, among other things, examine the incidence of operational errors misclassified as pilot deviations at other air traffic facilities nationwide. The OIG's *preliminary* findings did not indicate that the underreporting of operational errors/deviations was occurring nationwide. The OIG did not make any final conclusions and expects to release the audit results early next fiscal year. I am confident that the OIG will conduct a complete and comprehensive evaluation of this matter.

In addition to these internal DOT efforts, in April of this year I convened an independent panel of renowned aviation and safety experts to comprehensively evaluate the FAA's implementation of the aviation safety system and its culture of safety. I expect to receive the panel's recommendations in early September and intend to share the results with you.

As I mentioned in my April 24 letter, we are committed to maintaining the highest levels of transportation safety throughout the nation and consider the underreporting of operational errors to be a serious deficiency that must be prevented.

The FAA is taking corrective action to address the issues raised in your referral and validated by the OIG, by holding management accountable, improving processes and procedures, and making organizational changes to continually improve our safety records. As noted above, I will keep you apprised of additional information concerning these matters as it becomes available.

Sincerely yours,

Mary E. Peters

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