THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

April 24, 2008

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

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

USOSC HQ DC '08APR24

Dear Mr. Bloch:

Thank you for your correspondence of July 9 and July 19, 2007, concerning whistleblower allegations that management officials at FAA's Dallas-Fort Worth (DFW) Terminal Radar Approach Control (TRACON) facility "covered-up" air traffic controller operational errors and deviations by misclassifying them as pilot deviations or "non-events," or by failing to investigate them. The whistleblowers, including Anne Whiteman, a senior DFW Control Tower Supervisor, also expressed concern that TRACON management's misclassification of operational errors/deviations may reflect an FAA-wide effort to keep the number of operational errors/deviations artificially low. I delegated responsibility for investigating the above matters to the Department's Inspector General, who has concluded his investigation and provided me the enclosed memorandum report containing his findings and recommendations.

In short, for the second time in three years, the Office of Inspector General (OIG) substantiated whistleblower allegations that DFW TRACON management underreported operational errors/deviations — creating, at a minimum, the appearance of cover-up. The OIG's previous investigation exposed a seven-year management practice at this TRACON of improperly investigating and underreporting operational errors. This time, the OIG found that in response to the findings and recommendations of its prior investigation, DFW TRACON management went through the process of investigating suspected operational errors/deviations, but routinely misclassified them as pilot deviations or non-events. Specifically, between November 2005 and July 2007, DFW TRACON management misclassified 52 controller operational errors and 10 operational deviations as pilot deviations or non-events. Significantly, 15 of these 52 were serious Category "A" and "B" operational errors (3 and 12, respectively).

Although the OIG found compelling evidence to conclude that the misclassifications were intentional, it was unable to ascribe a specific motive to TRACON management for doing so. However, the OIG did not find any evidence that they acted in response to any direction from FAA senior leaders or an FAA-wide policy. Further, based on a limited period of review during its investigation, the OIG found DFW TRACON's incidence of operational error/deviation misclassification to be significantly higher than that of other large TRACONs (25% vs. 3%, respectively). An ongoing OIG audit is examining the incidence of operational errors misclassified as pilot deviations at other air traffic facilities nationwide, the preliminary results of which are consistent with the finding in this investigation for other large TRACONs.

In both investigations, the OIG found a lack of proper oversight within FAA. In the present case, failures by the TRACON's Quality Assurance office and the Headquarters-based Safety Service of FAA's Air Traffic Organization (ATO-Safety) enabled DFW TRACON management again to underreport operational errors/deviations.

Based on the gravity of these findings, the Inspector General issued a report to the Acting FAA Administrator recommending that he take action to preclude recurrence of underreported operational errors at DFW TRACON. The Inspector General's recommendations to FAA include:

- Permanently change DFW TRACON management, as well as consider appropriate administrative action for the seven TRACON managers who bear responsibility for the misclassification and underreporting of operational errors/deviations.

- Require FAA's Air Traffic Safety Oversight Service (AOV, which is independent of the ATO) to conduct comprehensive, on-site, "no-notice" audits at DFW TRACON to ensure accurate, straightforward investigation and reporting of operational errors/deviations.

- Expedite deployment of the Traffic Analysis and Review Program (TARP), a state-of-the-art automated system that detects losses of separation, at the DFW TRACON.

- Remove the Quality Assurance function at all Air Traffic Control facilities from the supervision of facility management, due to an inherent conflict of interest which creates the potential for inaccurate reporting of operational errors/deviations.

- Conduct a top-to-bottom review of ATO-Safety's management, staffing and processes to ensure it provides effective internal oversight for ATO.

In response to the Inspector General's report, Acting Administrator Sturgell issued the enclosed memorandum, in which he expressed to me how troubled he is by the investigation's findings, and his appreciation of the whistleblowers for bringing these serious improprieties to light. I, too, am grateful for the diligence of these dedicated employees in coming forward in the interest of improving aviation safety.

The Acting Administrator accepted and is implementing each of the Inspector General's recommendations, and has also committed to additional actions to prevent future unreported operational errors/deviations at DFW TRACON and all air traffic facilities system-wide. The Inspector General and I have reviewed the Acting Administrator's memorandum and believe FAA's actions address the Inspector General's findings and recommendations. Nonetheless, because the FAA did not satisfactorily carry out its previous oversight commitments, I am directing that the Acting Administrator regularly report to me on the status of FAA's corrective actions in this matter.

I have established transportation safety as the Department's top strategic goal. To that end, I, along with the Acting Administrator, consider the underreporting of operational errors, which pose substantial safety risks, to be a serious deficiency that must be prevented. We assure you that the FAA will follow through on its corrective action commitments in this important matter.

If you have any questions or require further information, please feel free to contact me or Acting Administrator Sturgell.

Sincerely yours,

Mary E. Peters

Mary E. Peters

Enclosures (2)

Memorandum

U.S. Department of Transportation
Office of the Secretary of Transportation
Office of Inspector General

Subject: ACTION: OIG Investigation — Alleged Cover-up of Operational Errors at DFW TRACON

Date: April 18, 2008

From: Calvin L. Scovel III
Inspector General

Reply to attn of:

To: The Secretary

This presents our investigative findings and recommendations stemming from whistleblower allegations that management officials at the Federal Aviation Administration's (FAA) Dallas-Fort Worth (DFW) Terminal Radar Approach Control (TRACON) facility "covered-up" air traffic controller operational errors and deviations[1] by: (a) misclassifying them as pilot deviations[2] or "non-events," and (b) failing to investigate and/or report suspected operational errors and deviations. The whistleblowers also expressed concern that DFW TRACON management's misclassification of operational errors/deviations may reflect an FAA-wide effort to keep the number of operational errors/deviations artificially low.

FAA policy requires the management of each TRACON and other air traffic control facilities to investigate all suspected operational errors/deviations. Because

[1] An *operational error* occurs when an air traffic controller allows aircraft to come too close together. More specifically, an operational error occurs when less than 90% of the minimum separation standard between two or more aircraft, or an aircraft and terrain/obstacles, is met. For TRACON facilities, the minimum Instrument Flight Rule separation standard, with some exceptions, is 3 miles horizontally or 1,000 feet vertically.

An *operational deviation* occurs when an aircraft in airspace controlled by one air traffic controller encroaches upon, or flies into, airspace assigned to another controller without proper coordination.

[2] A *pilot deviation* occurs when the actions or inactions of a pilot result in the violation of a Federal Aviation Regulation (FAR). A pilot deviation may or may not result in a loss of the minimum separation standard between two or more aircraft, or an aircraft and terrain/obstacles.

operational errors/deviations are important indicators of air traffic safety, it is critical that management thoroughly investigate and accurately report them, and take appropriate action, including retraining or removing controllers, to address their causes and prevent recurrence.

The above allegations, which were referred to you by the U.S. Office of Special Counsel (OSC) on July 9 and July 19, 2007, were raised by three whistleblowers: (1) Anne Whiteman, a senior DFW Control Tower supervisor; (2) a confidential DFW TRACON employee; and (3) Don Craig, a retired DFW TRACON air traffic controller. Ms. Whiteman and the confidential source identified multiple instances where they assert DFW TRACON management misclassified operational errors/deviations as pilot deviations or non-events. Mr. Craig cited several instances where he asserted DFW TRACON operations supervisors failed to investigate suspected operational errors/deviations.

You delegated investigation of these allegations to our office. If you accept the results of our investigation, we recommend you transmit this report to the Special Counsel, along with a statement of FAA corrective action in response to our findings and recommendations.

EXECUTIVE SUMMARY

For the second time in three years, we have substantiated whistleblower allegations that DFW TRACON management underreported operational errors/deviations — creating, at a minimum, the appearance of cover-up. Our previous investigation exposed a 7-year management practice at this TRACON of improperly investigating and, therefore, underreporting operational errors. This time, we found that in response to the findings and recommendations of our prior investigation, DFW TRACON management went through the process of investigating suspected operational errors/deviations, but routinely misclassified them as pilot deviations or non-events. Although we found compelling evidence to conclude that the misclassifications were intentional, we were unable to ascribe a specific motive to TRACON management for doing so. Even if the evidence is not viewed as conclusive that TRACON management engaged in deliberate misclassification, because they misclassified operational errors (as pilot deviations) at a rate eight times that of other TRACONs nationwide (25% vs. 3%, respectively), the only alternative is to conclude they were negligent or incompetent.

In both of our investigations, we found a lack of proper oversight within FAA. In the present case, failures by the local Quality Assurance function (which directly reports to TRACON management) and the Headquarters-based Air Traffic Organization (ATO)-Safety Service (responsible for ensuring implementation of corrective actions from our first investigation) enabled DFW TRACON management to again

underreport operational errors/deviations. We did not, however, find that FAA senior leadership, including the ATO-Terminal Service Vice President, was aware of DFW TRACON management's misclassification, and thus underreporting, of operational errors/deviations.

FAA must finally take decisive and comprehensive action to preclude recurrence of underreported operational errors at DFW TRACON. We have presented our findings and recommendations in this matter to FAA's Acting Administrator. As detailed later in this report, our recommendations to FAA include:

- Permanently change DFW TRACON management, as well as take appropriate administrative action for seven TRACON managers who bear responsibility for the misclassification, and thus underreporting, of operational errors/deviations.[3]

- Require FAA's Air Traffic Safety Oversight Service (AOV, which resides outside ATO) to conduct comprehensive on-site, "no-notice" audits at DFW TRACON to ensure accurate, straightforward investigation and reporting of operational errors/deviations.

- Expedite deployment of the Traffic Analysis and Review Program (TARP), a state-of-the-art automated system that detects losses of separation, at the DFW TRACON.

- Remove the Quality Assurance function at all Air Traffic Control facilities from the supervision of facility management, due to an inherent conflict of interest which creates the potential for inaccurate reporting of operational errors/deviations.

- Conduct a top-to-bottom review of ATO-Safety's management, staffing and processes to ensure it provides effective internal oversight for ATO.

- Consider appropriate administrative action for two ATO-Safety officials, whose failure to carry out proper follow-up reviews following our initial investigation enabled TRACON management to again underreport operational errors/deviations.

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[3] Relative to administrative action consideration, we note that as a result of our prior investigation, FAA placed the TRACON Manager and two of the three Operations Managers on performance improvement plans (called "Opportunity to Demonstrate Performance") for failing to abide by FAA policy regarding investigating and reporting operational errors.

Although unreported operational errors at DFW TRACON constitute a safety deficiency that must be wholly remedied, we note that there have been no serious accidents at DFW International Airport (the third-busiest airport in the world, operating more than 1,900 flights daily and serving 60 million passengers a year) in over ten years, and no accident has ever been attributed to a DFW air traffic controller.[4]

METHODOLOGY

The OIG-led investigative team was comprised of OIG senior investigators and an aviation analyst/former air traffic controller; air traffic controllers and other technical aviation experts from FAA's Air Traffic Safety Oversight Service (AOV)[5]; and a pilot from FAA's Flight Standards Service.

We investigated the incidents identified by the whistleblowers (occurring between November 1, 2005, and June 3, 2007) where DFW TRACON management allegedly misclassified 12 operational errors/deviations as pilot deviations or non-events. We examined voice and radar data, as well as pertinent documents (e.g., Quality Assurance Reviews[6]), associated with each incident.

We also examined hundreds of hours of voice and radar data, as well as documentation, for all pilot deviations reported by DFW TRACON from January 1, 2006, to July 13, 2007, to determine if any of those pilot deviations should have been properly classified as an operational error or deviation. Additionally, we reviewed all pilot deviation reports involving a loss of separation from other TRACONs nationwide

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[4] In October 2007, DFW International Airport received the Flight Safety Foundation's "2007 Airport Safety Award."

[5] AOV was established on March 14, 2005, by the FAA Administrator in response to recommendations made by the National Civil Aviation Review Commission and the International Civil Aviation Organization that air traffic service providers be subject to safety oversight by an FAA entity outside ATO. AOV has the full range of authority to develop or adopt safety standards and to ensure that ATO complies with those standards. AOV is part of FAA's Aviation Safety Organization, and provides independent oversight of the ATO in a manner structurally similar to FAA's oversight of air carriers.

[6] A Quality Assurance Review (QAR) is conducted by TRACON management or Quality Assurance staff into an air traffic incident to determine whether controller performance, procedures and/or equipment may have contributed to, increased the severity of, or unreasonably failed to mitigate the incident.

for the period March 1, 2007 to July 13, 2007, along with a sample of accompanying radar and voice data, to determine if any of those pilot deviations were misclassified.[7]

We also examined the five suspected operational errors/deviations cited by Mr. Craig to determine if DFW TRACON management investigated them as required by FAA policy. We reviewed available voice and radar data, as well as documentation, for these incidents. In order to determine if other suspected operational errors/deviations had not been investigated, we reviewed a random sample of DFW TRACON voice and radar data for the 45-day period that preceded the beginning of this investigation.[8]

Finally, we conducted over 60 interviews, including:

- Ms. Whiteman, the confidential source, and Mr. Craig;
- DFW TRACON air traffic controllers, supervisors, and managers;
- DFW Quality Assurance staff (current and former);
- FAA Central Region Service Center Safety Assurance managers and staff;
- FAA Headquarters Air Traffic Organization (ATO) — Safety Service, Acting Director of Investigations and Evaluations, and staff;
- DFW and Dallas Love Field Flight Standards District Office (FSDO) safety inspectors and managers;
- FAA ATO — Director of Terminal Safety; and
- FAA ATO — Vice President of Terminal Service.

[7] Given the large volume of data to review and time and resource constraints, we limited the period of this specific review to March 1, 2007, through July 13, 2007 (the date our investigation commenced).

[8] FAA policy requires retention of radar data for a minimum of 45 days; generally, the data is destroyed thereafter.

DETAILS

Results of Our Prior Investigation

In February 2005, we reported to then-Secretary Norman Mineta that DFW TRACON management routinely failed to investigate suspected operational errors/deviations that occurred between March 2002 and June 2004.[9] We found the failure to investigate operational errors/deviations resulted from the former TRACON Manager's practice, begun in 1996, of having supervisors rely on the word of controllers as to whether they committed operational errors/deviations, and not following FAA policy requiring formal investigation of suspected operational errors by use of "playback tools."[10]

The fact that this systemic practice at DFW went undetected for so many years led us to conclude that there was a marked lack of oversight by the TRACON's Quality Assurance unit, whose primary function was to review investigations of suspected operational errors conducted by facility management, and Regional and Headquarters elements of FAA. We also concluded there was a lack of oversight by the succeeding TRACON Manager. In fact, she told us she was unaware of her predecessor's practice of restricting the use of playback tools. When we informed the TRACON Manager of our findings, she said she felt responsible for not having provided adequate oversight, and promptly issued a policy memorandum to her staff directing immediate use of playback tools to investigate all suspected operational errors. Because the TRACON Manager was relatively new to her position and maintained she was unaware of her predecessor's improper practice, and in light of her issuance of a corrective policy, we did not recommend that FAA pursue administrative action against her.

FAA also committed to other actions to remedy the deficiencies at the DFW TRACON; e.g., the Quality Assurance Manager was replaced and FAA Headquarters' ATO — Safety Evaluations committed to conduct no-notice reviews for two years to assess whether managers investigated and accurately reported all suspected operational

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[9] OIG Report #CC2004-067, "Alleged Cover-up of Operational Errors at DFW TRACON," dated February 14, 2005. (Available on our website at www.oig.dot.gov – posted June 24, 2005.)

[10] Playback tools are software programs and other electronic instruments for recreating air traffic incidents by replaying recorded radar and voice data on standard desktop computers.

errors/deviations.[11] In 2005, FAA gave assurances that its oversight would not allow DFW TRACON operational errors/deviations to go unreported. Clearly, as shown below, FAA's actions and assurances were not effective in preventing unreported operational errors/deviations at DFW TRACON.

Results of Our Most Recent Investigation

DFW TRACON management has again underreported controller operational errors/deviations.

We found DFW TRACON management has continued to underreport controller operational errors/deviations, this time by misclassifying them. In some instances, instead of properly finding the controller responsible for the loss of separation, TRACON management wrongly faulted the pilot. In other instances, although TRACON management properly cited a pilot as bearing responsibility for the loss of separation, they failed to also properly identify the controller's responsibility. Finally, in the remaining instances, TRACON management declared a "non-event," i.e., they incorrectly concluded there was no loss of separation.[12]

Specifically, we found:

- Between November 1, 2005, and July 13, 2007, DFW TRACON management misclassified 62 air traffic events as pilot deviations or non-events — consisting of 52 operational errors and 10 operational deviations.[13] Significantly, 15 of these 52 operational errors (nearly 1 in 3) were serious Category "A" and

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[11] ATO-Safety is responsible for improving the safety of the air traffic control system by, among other things, investigating losses of separation between aircraft. ATO-Safety is required to review incidents and identify leading indicators (human, mechanical, procedural) or other safety hazards which may have contributed to the losses of separation.

[12] Following TRACON investigation, each air traffic event is classified as: (a) a controller operational error or deviation; (b) a controller operational error/deviation *and* a pilot deviation; (c) a pilot deviation; or (d) a "non-event," i.e., the prescribed minimum separation between aircraft was maintained.

[13] A list of these operational errors/deviations is appended to this report as Attachment 1.

"B" operational errors (3 and 12, respectively).[14] These 62 misclassified events are further broken down as follows:

- Of the 12 suspected operational errors cited by Ms. Whiteman and the confidential source, DFW TRACON management misclassified 10 as pilot deviations (when either no pilot deviation occurred or both an operational error *and* a pilot deviation occurred) and 2 as non-events.

- DFW TRACON management misclassified 50 other operational errors/deviations[15]: 29 as pilot deviations (when, in fact, either no pilot deviation occurred, or both an operational error *and* a pilot deviation occurred) and 21 as non-events.

- Between January 1, 2006, and July 13, 2007, 29% of pilot deviations involving a loss of separation reported by the DFW TRACON (37 of 129) were actually misclassified operational errors/deviations.

- From March 1, 2007, through July 13, 2007, we found that 25% of pilot deviations filed by DFW TRACON management (8 of 32) should have been properly classified as operational errors. In stark contrast, for the same time period, approximately 3% of pilot deviations reported by other TRACONs nationwide (14 of 533) should have been classified as operational errors/deviations.[16]

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[14] FAA categorizes operational errors by severity. Category "A" is the most severe; a "proximity event," formerly known as Category "D," is the least severe. A narrative describing the three Category "A" operational errors we found is at Attachment 2.

[15] For the period January 1, 2006, to July 13, 2007.

[16] Given the large volume of data to review and time and resource constraints, we limited the period of this specific review to March 1, 2007, through July 13, 2007 (the date our investigation commenced).

Compelling evidence that DFW TRACON management intentionally misclassified operational errors/deviations.

- ***Culpable DFW TRACON management and their typical investigative and reporting process***

We identified seven managers at DFW TRACON who bear responsibility for the misclassification and thus underreporting of operational errors/deviations:

- TRACON Manager
- Assistant TRACON Manager
- 2 Quality Assurance Managers
- 3 Operations Managers

We found that, typically, when a controller reported a possible operational error/deviation or pilot deviation, the Operations Manager on duty investigated the incident using voice and radar data and made an initial determination. If the Operations Manager's initial determination was that the incident was an operational error/deviation or pilot deviation, he met with the Quality Assurance Manager and either the Assistant TRACON Manager or the TRACON Manager to review the incident. Although either the Assistant TRACON Manager or the TRACON Manager was responsible for the final determination, each of the seven managers told us that, for each incident under review, the determination was reached by consensus among the managers.[17]

When the Operations Manager's initial determination was that the incident was a non-event, his determination was reviewed by the Quality Assurance Manager. If the Quality Assurance Manager concurred, the investigation was closed without further review by either the Assistant TRACON Manager or the TRACON Manager, although the Operations Manager could, and did, consult with the TRACON Manager or Assistant TRACON Manager, or both. Although the Assistant TRACON Manager and TRACON Manager were not required by FAA policy or procedure to review non-event determinations, they are nonetheless responsible, by virtue of their positions

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[17] Each TRACON's Quality Assurance Manager reports to the TRACON's Manager and Assistant TRACON Manager. The TRACON Manager and Assistant TRACON Manager, who have a vested interest in a low number of operational errors/deviations, are responsible for evaluating the Quality Assurance Manager's performance. Thus, the Quality Assurance Manager has an inherent conflict of interest between recommending a finding of an operational error/deviation to his or her supervisors and the possible effect of doing so on his or her performance evaluation.

and the TRACON Manager's prior commitment to stringent oversight, for their accuracy.

In cases where the Quality Assurance Manager disagreed with the Operations Manager's initial determination of a non-event and believed the incident was an operational error/deviation or pilot deviation, or was uncertain that the incident should be classified as a non-event, the Quality Assurance Manager reviewed the incident with either the Assistant TRACON Manager or the TRACON Manager for final determination.

- ***Specific evidence of intentional misclassification***

We have concluded that a culture existed at the TRACON in which management's goal was to avoid citing controllers with operational errors/deviations. Although we were unable to ascribe a specific motive for such a goal, circumstantial evidence described below indicates that DFW TRACON management's means for accomplishing this goal entailed intentionally misclassifying operational errors/ deviations.

First, the Assistant TRACON Manager and an Operations Manager told us they believed it was their job to find a way to avoid placing blame on the controller for a loss of separation. In addition, a confidential source told us this was a general practice at the facility. Despite their qualification to us that they meant finding a way within the rules, our investigation reflects the TRACON management's willingness to manipulate evidence and render unreasonable determinations favorable to controllers, but detrimental to aviation safety. For example, TRACON managers often intentionally ignored the most relevant radar data when investigating a suspected operational error/deviation. Specifically, they selected radar data from a sensor showing aircraft separation greater than 1,000 feet or 3 miles, rather than data from the sensor associated with the scope the controller was viewing at the time of the incident (which often indicated a loss of separation).[18] Similarly, they closed investigations of suspected operational errors as non-events after finding that controllers and pilots were in proper coordination with one another *before* the loss of separation occurred. However, voice and radar data show that the coordination came *after* the loss of separation. Given the obviousness of this data, management likely was — or should have been — aware the incidents were, in fact, operational errors/deviations.

[18] We learned that DFW's three radar sensors, which measure aircraft separation distance, can produce results that vary as much as 300 feet for the same air traffic event.

Second, we found that each of the misclassified pilot deviations or non-events was obviously an operational error/deviation. Because of this, we concluded it was not reasonable for these seven experienced and knowledgeable managers to have mistakenly reported the operational errors/deviations as pilot deviations or non-events. In fact, FAA Central Region Service Center safety assurance investigators told us that, in some instances, they advised the TRACON Manager, the Assistant TRACON Manager and the Quality Assurance Manager that misclassified pilot deviations were, in fact, obvious operational errors. TRACON management, they told us, ignored their advice.

Third, DFW TRACON managers misclassified a substantially greater percentage of operational errors as pilot deviations than their counterparts at other large TRACONs. Specifically, 25% of the pilot deviations declared by DFW TRACON managers from March through July 2007 should have been declared operational errors. At other large TRACONs, 3% of the declared pilot deviations for that same period should have been declared operational errors.[19] Because the percentage of misclassified pilot deviations at DFW TRACON is 8 times greater than the percentage of misclassified deviations at other TRACONs nationwide, we have concluded that DFW TRACON's misclassifications cannot be attributed to mere mistake, especially in light of the other evidence of intent cited above.

Lack of proper FAA oversight following our prior investigation enabled TRACON management to again underreport operational errors.

In response to our prior investigative findings and recommendations, FAA committed to a number of actions to remedy the DFW TRACON deficiencies regarding the investigation and reporting of operational errors/deviations. We found FAA failed to carry out these critical commitments.

- ***ATO's lack of oversight***

Following completion of our last DFW TRACON investigation in early 2005, senior FAA officials, including the ATO-Terminal Service Vice President, committed to

[19] We are conducting an audit, initiated in November 2007, at the request of the House Committee on Transportation & Infrastructure, to: (a) determine whether FAA has adequate policies and procedures in place to ensure the accuracy of operational error reporting; and (b) review the roles and responsibilities of the ATO and Aviation Safety lines of business in reporting and investigating operational errors. Additionally, our audit is examining the incidence of operational errors misclassified as pilot deviations at other air traffic facilities nationwide, the preliminary results of which are consistent with the finding in this investigation for other large TRACONs.

remedying the deficiencies in operational error investigation and reporting at DFW TRACON. Further, ATO-Safety was tasked with conducting "no-notice" reviews of the DFW TRACON for two years. This meant, among other things, that ATO-Safety officials would appear at the facility unannounced to assess whether suspected operational errors were thoroughly investigated and accurately reported. We found, however, ATO-Safety's last no-notice review of the DFW TRACON occurred in June 2005. Since then, ATO-Safety officials have randomly reviewed DFW TRACON radar data for operational errors from their offices in Washington and Boston and only required DFW TRACON management to complete a "Facility Self-Assessment" worksheet. Not surprisingly, TRACON management reported the facility was in "100% compliance" with the operational error investigation process. ATO-Safety officials did not, however, attempt to verify DFW TRACON's self-assessment, and they provided reports to ATO-Terminal, as well as our office, that operational errors were being properly investigated and reported at DFW TRACON.

Moreover, part of ATO-Safety's mission is to review loss-of-separation events, including pilot deviations and operational errors/deviations, at all TRACONs to determine if significant safety issues exist. ATO-Safety has asserted that because it had an insufficient number of investigators prior to March 2007, as few as two at times, it could not adequately review pilot deviations. According to statements we received from current ATO-Safety investigators, they still do not review controller operational deviations.

We have concluded that primary responsibility for ATO-Safety's oversight failures at DFW TRACON rests with one investigator (who later assumed the role of Acting Director) and the then-Acting Director (later assuming the position of Acting Vice President of ATO-Safety). We found no evidence, however, that they deliberately failed to conduct no-notice reviews or examine pilot deviation reports.

We did not find evidence that FAA senior leadership, including the ATO-Terminal Service Vice President and the ATO-Terminal Director of Safety, had awareness of DFW TRACON management's misclassification, and thus underreporting, of operational errors/deviations. The ATO-Terminal Vice President told us they relied on the representations of ATO-Safety that operational errors at DFW TRACON were being properly investigated and reported. Nonetheless, we believe the ATO-Terminal Service Vice President and ATO-Terminal Director of Safety carry some level of responsibility for the misclassification of operational errors/deviations at DFW TRACON by virtue of their ATO leadership positions, and the ATO-Terminal Service Vice President's commitment to correcting the deficiencies at the TRACON identified in our prior investigation.

- ***Southwest Region FSDOs did not independently validate TRACON-declared pilot deviations***

To recap, we found DFW TRACON management misclassified 39 operational errors (10 identified by Ms. Whiteman and the confidential source, and 29 others we identified[20]) as pilot deviations[21] — when, in fact, either no pilot deviation occurred, or both an operational error *and* a pilot deviation occurred. Although each of these 39 air traffic events involved a controller operational error, some may have also involved a pilot deviation.

Pursuant to FAA policy, DFW TRACON management reported the 38 above-referenced pilot deviations to the FAA Southwest Region's DFW and Dallas Love Field FSDOs for independent validation that pilot action caused the loss of separation and, if appropriate, for initiation of compliance/enforcement action against the responsible pilot. The FSDO inspectors told us they sometimes relied solely on the TRACON's determination that a pilot deviation occurred. In particular, they did not review DFW TRACON pilot deviation reports when the airline employing the pilot in question participated in the Aviation Safety Action Partnership (ASAP) program.[22] Instead, FSDO inspectors presumed that the TRACON's pilot deviation report was accurate and then, despite the fact that the ASAP program is intended for pilots to self-report violations, forwarded the form documenting the pilot deviation to the appropriate FAA Certificate Management Office (CMO) for review by ASAP officials.

If ASAP program officials found there was a pilot deviation, they could initiate corrective measures, but not punitive action against the pilot. If they determined the loss of separation was not caused by the pilot's actions, the matter was simply dropped; it was not referred back to the DFW TRACON, via the FSDOs, for

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[20] See page 8 of this report.

[21] One of the 38 pilot deviation reports contained two misclassified operational errors, thus the 38 reports contained a total of 39 misclassified operational errors.

[22] ASAP is a voluntary reporting program in which pilots employed by participating airlines can report any incident that may raise a safety concern, or any circumstances where safety might have been compromised, without fear of being subjected to an enforcement action. A team of representatives from the airline, the pilots' union, and FAA then review the event in order to determine possible violations or impact on aviation safety. The resolution of events reflects an emphasis on correcting the problems rather than punitive actions for pilots.

reconsideration of a possible controller operational error to account for the loss of separation.[23]

If the airline employing the pilot in question did not participate in the ASAP program, FSDO officials, in some instances, initiated compliance/enforcement action against the pilot.[24] However, because some of those "pilot deviations" were actually misclassified operational errors that did not involve pilot deviations, enforcement action may have been unwarranted. We requested that AOV determine whether any unwarranted enforcement action occurred. AOV found that although at least three pilots received letters of warning or correction, no pilots were subjected to an enforcement action (such as a proposed certificate suspension) as a result of an operational error misclassified as a pilot deviation.

We did not find evidence that DFW TRACON management misclassified operational errors/deviations in response to any direction from FAA senior leaders or an FAA-wide policy. Nor did we find evidence that FAA's pay-for-performance system contributed to TRACON management's misclassification.

We also investigated the whistleblowers' concern that DFW TRACON management's misclassification of operational errors/deviations may reflect an FAA-wide effort to keep the number of operational errors and deviations artificially low. As evidence of such an effort, the whistleblowers asserted: (a) since a June 2006 national meeting of Air Traffic managers in Washington, DC, during which the topic of reducing operational errors was discussed, the number of pilot deviations has increased; and (b) in a June 2007 statement to the media, then-FAA Administrator Marion Blakey stated that although air traffic controllers do commit operational errors or deviations, "frequently it is the pilot, what we call a pilot deviation, a pilot error."

We found no evidence that then-Administrator Blakey or any other member of FAA leadership directed, explicitly or implicitly, that Air Traffic managers underreport operational errors/deviations. We interviewed five DFW TRACON managers and several of our investigative team members from AOV who attended the June 2006 meeting, as well as smaller group follow-up meetings in 2007. Each told us that although attendees and speakers discussed ways to pursue FAA's goal of reducing controller operational errors, no FAA senior leader or, for that matter anyone else, said

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[23] In those instances where FSDO inspectors determined that pilot action did not cause the loss of separation, we found no evidence they returned the loss of separation report to the TRACON to reconsider the air traffic event as an operational error.

[24] Compliance-related action for a pilot includes letters of correction or warning. Enforcement action includes proposed pilot certificate (a/k/a "license") suspension or revocation.

anything that could be construed as policy or direction to underreport operational errors/deviations.

Consequently, we found no evidence that any FAA-wide policy, express or implied, directed Air Traffic managers to underreport operational errors/deviations. None of the persons we interviewed knew of any FAA policy or direction to suppress the reporting of operational errors/deviations. In fact, if there was such a policy or direction, other TRACONs likely would have misclassified operational errors/deviations as pilot deviations at a rate similar to DFW. As previously addressed, however, other TRACONs misclassified a significantly lower percentage of operational errors/deviations as pilot deviations.

Finally, we found no evidence that FAA's pay-for-performance system contributed to DFW TRACON management's misclassification of operational errors/deviations. Moreover, it is unlikely that there is any evidence that FAA's pay-for-performance system contributed to DFW TRACON management's cover-up of operational errors.

FAA utilizes a performance-based system for compensating executives and over 80% of employees. For employees covered by this system, their pay raise is based on an organizational success increase (OSI). The DFW TRACON is just one of over 125 TRACONs nationwide and DFW employees constitute a small percentage of the FAA employees covered by this system. Moreover, an OSI payout requires that FAA, as a whole, meet at least 90%, or 27 out of 30, "Flight Plan Performance Targets" and reduction of operational errors is but one of the 30 performance targets. Given the above, the ability of employees at any one facility to affect a single national performance target, (e.g., operational errors), let alone 27 of 30, is negligible.

The Assistant DFW TRACON Manager improperly authorized controllers to apply a specific procedure during "parallel final approaches," which caused operational errors.

During the course of our investigation, we discovered 11 instances in which the Assistant DFW TRACON Manager authorized controllers to apply a specific procedure, intended to more efficiently control aircraft, which caused a loss of separation. These 11 operational errors — not included in the 62 previously addressed in this report — occurred while controllers handled two aircraft arriving at the same time on parallel runways.

FAA Order 7110.65 requires a controller performing parallel final approaches to ensure that both aircraft have *completed* a turn and are fixed on their "localizer"[25]

[25] A "localizer" is a beacon-type transmitter that provides runway centerline guidance to the pilot of an aircraft operating on an Instrument Landing System (ILS) approach.

before allowing them to discontinue the 1000 foot vertical separation requirement and begin their descent for landing. According to our AOV experts, DFW TRACON controllers issued instructions to one or both pilots and failed to ensure the required separation was maintained while the aircraft were turning toward the localizer. The controllers, however, told our AOV experts that the Assistant TRACON Manager authorized this procedure in order to more efficiently control aircraft.

The Assistant TRACON Manager asserted that a loss of separation was permissible while executing this procedure and, as such, did not cause an operational error. According to our AOV experts, however, this procedure clearly violated FAA policy, thus constituting operational errors. Based on the obviousness of the violation, and because of his knowledge and experience, we concluded the Assistant TRACON Manager knew — or should have known — that the procedure he authorized was not permissible.

We did not find evidence that DFW TRACON Operations Supervisors failed to investigate five suspected operational errors/deviations. However, we found that an Operations Manager, after investigation, misclassified one of the incidents as a pilot deviation when it should have been declared an operational error.

FAA Order 7210.56C requires that all system deficiencies be identified and corrected. If a suspected loss of separation event is determined to be an operational error or deviation, an initial investigation is required. This investigation is to determine what occurred in the system, to ensure corrective action is initiated to maintain system integrity, and to report significant events to higher levels of management.

Supervisors and Operations Managers begin a QAR by reviewing the data associated with a suspicious event or system anomaly (as per FAA Order 7210.56). If the data indicates a possible operational error or deviation, the QAR is closed and an initial operational error or deviation investigation is begun. (The operational error investigation requires, in addition to review of voice and radar data, written controller statements.) If the data does not indicate a possible operational error or deviation, the QAR form is completed by the supervisor or Operations Manager and sent to the Quality Assurance office for review. The Quality Assurance staff will review the QAR and recommend actions or closure to the Quality Assurance Manager. The Quality Assurance Manager reviews each QAR and either authorizes its closure or directs subordinate staff to document the event as an operational error or deviation or pilot deviation. The order also prescribes corrective actions to be taken by management, including retraining responsible air traffic controllers, or removing them from duty.

Mr. Craig alleged that, as part of a cover-up of operational errors, DFW TRACON Operations Supervisors did not investigate five suspected operational errors and

deviations that he reported. Specifically, he identified suspected operational errors that occurred on September 4 and September 12, 2006, and suspected operational deviations that occurred on July 4, August 11 and September 4, 2006.

We found that DFW TRACON management completed over 200 QARs during the period of the five incidents in question, i.e., July 4, 2006, through September 12, 2006. We found that an Operations Manager investigated the July 4, 2006, suspected operational deviation, but closed it as a non-event. Our AOV experts, however, were unable to verify that the incident was accurately reported as a non-event because the corresponding radar data was destroyed, in compliance with FAA policy, 45 days after the July 4 incident. We also found that this same Operations Manager investigated the September 4, 2006, suspected operational error, and reported it as a pilot deviation on the ground that the pilot did not respond quickly enough to the controller's instructions to turn. However, our AOV experts determined the controller's instruction came too late for the pilot to maintain 1000 feet of vertical separation from another aircraft and, therefore, the incident should have been reported as an operational error, instead of a pilot deviation.

The existence of QARs for the above two incidents indicates DFW TRACON Operations Managers investigated them. We were unable to locate QARs for the other three incidents; however, as shown below, this does not necessarily indicate the incidents occurred and that DFW TRACON management failed to investigate them.

Mr. Craig stated he orally reported a suspected operational deviation to his supervisor on August 11, 2006, though there was no witness to his report. However, the supervisor told us he did not recall Mr. Craig making this report, and we found no record of the report. Mr. Craig also stated he orally reported a suspected operational error to this same supervisor on September 4, 2006. Again, there was no witness to his report and we found no record of it. Moreover, the supervisor gave us travel receipts showing he was not in Dallas that day. Finally, although Mr. Craig stated that a supervisor witnessed a suspected operational error on September 12, 2006, and did not investigate it, he could not identify the supervisor for us, nor did he report the incident himself. Given the above findings, we are unable to show the alleged incidents occurred and, consequently, we are unable to show that DFW TRACON management failed to investigate them.

Recommendations

This is our second investigation confirming underreported operational errors/deviations at DFW TRACON within the last three years, creating, at a minimum, the appearance of cover-up. Based on the gravity of our findings, we consider it imperative that FAA take decisive, effective action to preclude recurrence of underreported operational errors at DFW TRACON. Accordingly, as formalized in

a memorandum to FAA's Acting Administrator dated April 9, 2008, we recommended that FAA:

1. Permanently change DFW TRACON management (foremost, the DFW TRACON Manager and Assistant TRACON Manager), as well as take appropriate administrative action for the seven TRACON managers, particularly the TRACON Manager, who bear responsibility for the misclassification, and thus underreporting, of operational errors/deviations.[26] In response to our prior investigation, the TRACON Manager committed to ensuring the proper investigation and accurate reporting of all operational errors/deviations. The evidence clearly reflects the TRACON Manager failed to fulfill this crucial responsibility. We note that as a result of our last investigation, the TRACON Manager and two of the three TRACON Operations Managers were placed on performance improvement plans (called "Opportunity to Demonstrate Performance") for failing to abide by FAA policy regarding investigating and reporting operational errors. This factor should be considered in determining appropriate administrative action.

2. Require AOV — vice ATO-Safety — to conduct comprehensive on-site, "no-notice" audits at DFW TRACON to ensure accurate, straightforward investigation and reporting of operational errors/deviations.

3. Expedite the early deployment of TARP, a state-of-the-art automated system that detects losses of separation (similar to the Operational Error Detection Program in place at "en-route" facilities nationwide), at the DFW TRACON. DFW TRACON is currently scheduled to implement TARP in 2011; however, it was one of FAA's test facilities for TARP. Thus, the equipment is already in place.

4. Remove the Quality Assurance function at all Air Traffic Control facilities from the supervision of facility management, due to the inherent conflict of interest which creates the potential for inaccurate reporting of operational errors/deviations.

5. Conduct a top-to-bottom review of ATO-Safety's management, staffing and processes to ensure it provides effective internal oversight for ATO.

6. Consider appropriate administrative action for ATO-Safety officials whose failure to conduct required "no-notice" reviews of DFW TRACON and examine all loss-of-separation events, (e.g., pilot deviations), enabled TRACON management to again underreport operational errors/deviations.

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[26] We understand that, as an interim measure, FAA has detailed the DFW TRACON Manager and Assistant TRACON Manager to positions outside the DFW TRACON.

7. Consider appropriate administrative action (e.g., training) for DFW and Dallas Love Field FSDO officials whose failure to validate pilot deviations reported by DFW TRACON management helped enable TRACON management to again underreport operational errors/deviations.

8. Examine all 38 TRACON-declared pilot deviation reports identified in our investigation. Where pilot deviations are determined not to be valid, rescind any compliance/enforcement actions against the affected pilots and expunge their records.

9. Reconsider selection of DFW as FAA's "Central Region Large TRACON Facility of the Year." The ATO-Terminal Services Vice-President publicly announced and presented this award to the DFW TRACON Manager during the August 2007 ATO National Managers' Conference, despite cognizance that we and AOV were investigating allegations that DFW TRACON management had again covered-up operational errors. Beyond the imprudence of this action, one criterion for the award was the number of facility operational errors. As demonstrated by our findings, DFW TRACON underreported operational errors for the period covered by this award, thereby rendering the data for this criterion invalid.

If I can answer any questions or be of further assistance, please contact me at x61959, or Theodore Alves, Deputy Inspector General, at x66767.

#

Incident Number	Date	Writtten Assessment	Assessed Category	Severity Conformance Rating	Separation Conformance Distances	OE/OD Filed	AFS Actions	Documentation	Simulation
Example 2, QAR 7323	5/17/2007	Click Here	OE	A	1.94*	DFWT07E010		Documentation	Replay
PSWRD1006017	2/13/2006	Click Here	OE	A	100/.97*		Reclassed/Insufficient	Documentation	Replay
PSWRD1006022	2/15/2006	Click Here	OE	A*	0/.64*		ASAP	Documentation	Replay
PSWRD1006060	6/13/2006	Click Here	OE	B	500/.5*	D10R06E039	EIR	Documentation	Replay
PSWRD1006002	1/7/2006	Click Here	OE	B*	300/1.31*		Counseling	Documentation	Replay
PSWRD1006010	1/26/2006	Click Here	OE	B*	0/1.6*		Possible EIR	Documentation	Replay
PSWRD1006040	4/2/2006	Click Here	OE	B*	400/1.31*		ASAP	Documentation	Replay
PSWRD1006046	4/28/2006	Click Here	OE	B*	100/1.75*		EIR/ASAP	Documentation	Replay
PSWRD1006097	10/11/2006	Click Here	OE	B*	400/1.97*		EIR	Documentation	Replay
PSWRD1006108	10/30/2006	Click Here	OE	B*	800/.86*		ASAP	Documentation	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PSWRD1006066	7/12/2006	Click Here	OE	B*	0/2.39	D10R06E036	None	Documentation	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PSWRD1006032	3/2/2006	Click Here	OE	C	600/1.48*	D10R06E038	ASAP	Documentation	Replay
PSWRD1006071	8/8/2006	Click Here	OE	C	700/1.93*	D10R06E041	Preliminary	Documentation	Replay
PSWRD1006081	9/4/2006	Click Here	OE	C	200/2.33*		Preliminary	Documentation	Replay
PSWRD1007027, QAR 6805	2/6/2007	Click Here	OE	C	700/1.67*	D10R07E040	ASAP	Documentation	Replay
PSWRD1007066	5/4/2007	Click Here	OE	C	800/.36*	D10R07E025	Reclassed/No Incident	Documentation	Replay
PSWRD1007084	6/3/2007	Click Here	OE	C	300/2.45*	D10R07E039	Letter of Correction	Documentation	Replay
QAR7859	[illegible]	[illegible]	OE	C	500/1.68*	[illegible]	[illegible]	[illegible]	[illegible]
PSWRD1006008	1/22/2006	Click Here	OE	C*	3.71*		Letter of Correction	Documentation	Replay
PSWRD1006041	4/6/2006	Click Here	OE	C*	700/1.93*		Reclassed/Insufficient	Documentation	Replay
PSWRD1006043	4/22/2006	Click Here	OE	C*	500/2.13*		EIR	Documentation	Replay
PSWRD1006045	4/28/2006	Click Here	OE	C*	0/4.45*		ASAP	Documentation	Replay
PSWRD1006070	8/6/2006	Click Here	OE	C*	700/2.22*		Preliminary	Documentation	Replay
PSWRD1006087	9/26/2006	Click Here	OE	C*	200/2.62*		Preliminary	Documentation	Replay
PSWTDFW06003	6/26/2006	Click Here	OE	C*	4.41*		Preliminary	Documentation	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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PSWRD1005049	11/1/2005	Click Here	2 OEs	C**	200/2.62	D10R05E036	Preliminary	Documentation	Replay
PSWRD1006082	9/10/2006	Click Here	OE	Insufficient Data	Unable to Det		Preliminary	Documentation	Replay
PSWRD1006138	12/19/2006	Click Here	OE	Insufficient Data	Unable to Det		ASAP	Documentation	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PSWRD1006053	5/15/2006	Click Here	OE	No Severity	0/1.01*		None	Documentation	Replay
Example 1, QAR 7212, 7213	4/25/2007	Click Here	OD	No Severity		DFWT07D007		Documentation	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
QAR 7851	2/6/2007	Click Here	OD	No Severity	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PSWRD1006029	2/25/2006	Click Here	OE	No Severity	[illegible]	[illegible]	[illegible]	Documentation	[illegible]
PSWRD1006073	8/17/2006	Click Here	OD	No Severity	[illegible]	[illegible]	EIR	Documentation	Replay
PSWRD1006092	10/8/2006	Click Here	OE(DAL)	No Severity	MVA	[illegible]	No violation/No Reclass	Documentation	Replay
PSWRD1006093	10/8/2006	Click Here	OE	No Severity	[illegible]	D10R06E037	Reclassed/No Incident	Documentation	Replay
QAR 7564	Jun-07	Click Here	OD (DFW)	No Severity	[illegible]	[illegible]	Data Was Not Available	Documentation	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Documentation	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
QAR 6429	12/2006	Click Here	OD	No Severity	[illegible]	[illegible]	[illegible]	[illegible]	Replay
QAR 6456	12/2006	Click Here	OD	No Severity	[illegible]	[illegible]	[illegible]	[illegible]	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
QAR 8031	Sep-07	Click Here	OE	No Severity	MVA	[illegible]	[illegible]	[illegible]	[illegible]
PSWRD1006124	11/27/2006	Click Here	PE	PE*	600/2.81*	[illegible]	[illegible]	[illegible]	Replay
PSWRD1007099	7/10/2007	Click Here	PE	PE*	500/2.99*	[illegible]	None	Documentation	Replay
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	None	Documentation	Replay

ATTACHMENT 1

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				
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[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				
Reportable Event 1	7/6/2007	Click Here	OE	C	800/2.51	D10R07E045		Documentation	[illegible]
Reportable Event 2	7/6/2007	Click Here	PE	PE	700/2.92				
Reportable Event 3	7/3/2007	Click Here	PE	PE	400/2.80				
Reportable Event 4	7/3/2007	Click Here	OE	C	800/2.54				
Reportable Event 5	7/3/2007	Click Here	OE	C	600/2.5				
Reportable Event 6	7/3/2007	Click Here	OE	C	200/2.64				
Reportable Event 7	7/5/2007	Click Here	OE	B	100/1.53				
Reportable Event 8	7/5/2007	Click Here	OE	C	500/2.51				
Reportable Event 9	7/5/2007	Click Here	OE	C	600/2.33				
Reportable Event 10	7/5/2007	Click Here	OE	C	400/2.32				
Reportable Event 11	7/5/2007	Click Here	OE	C	300/2.43				
Original Whistleblower		* Separation determined by RAPTOR. CDR Plot not available to AOV.							
QAR Identified at facility		** Indicates first incident:PSWRD1005049 between EGF256 and N1902P.							
[illegible]		Unable to determine severity of second incident due to lack of information (raptor or plot data).							
[illegible]									
[illegible]									
2006 Pilot Deviations									
2007 Pilot Deviations									
Whistleblower 1									
Whistleblower 2									
OIG									
Data Audit									

Attachment 2 – Verified "Category A" operational errors

Our analysis substantiated the following events as Category A operational errors (the most serious under FAA's classification system):

1) May 17, 2007

TRACON management's classification: ***Incident Closed as a Non-Event***

AOV reviewed this event and determined that an operational error occurred between American Eagle flight 600 (EGF600[1]) and American Airlines flight 806 (AAL806). EGF600 was vectored to runway 17 center (RY17C) on a final approach course to DFW and cleared for a visual approach. The approach controller failed to instruct the pilot to contact the tower. The tower controller continued to clear aircraft for departure on runway 17 right (RY17R.) When EGF600 was approximately 2 miles out from landing, the tower controller cleared AAL806 for take off on RY17R. AAL806, a Boeing 757, produces considerable wake turbulence, therefore aircraft are required to be a minimum of 4 miles behind the B757. The tower controller, not seeing EGF600, failed to issue a landing clearance. As a result, EGF600 did not land and the pilot executed a go around. The proper procedure for an aircraft that is executing a go around, absent ATC instructions is to fly runway heading and initiate a climb to a safe altitude. The tower controller's failure to issue a landing clearance to EGF600 caused a loss of separation with the departing Boeing 757.

Separation Conformance Distances[2] 1000 ft/1.94 mi., CATEGORY A

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[1] Aircraft are identified throughout this report by their call signs as reflected on FAA documents.

[2] Separation Conformance is the percentage of separation maintained at the closest proximity point and is calculated via a specific formula, or by using tables contained in FAA's Notice N JO 7210.663. Separation Distances used to classify any separation loss are written as lateral (horizontal) distance in nautical miles/vertical distance in feet, followed by the severity category A, B, C, or Proximity Event.

2) February 13, 2006

TRACON management's classification: ***Pilot Deviation filed as: PSWRD1006017***

AOV reviewed this event and determined that based on the data available, an operational error occurred. The controller assigned N24D 2,500 feet and instructed the aircraft to maintain 2,500 feet until midfield. The controller then released an aircraft (N444SS) from Addison field. The controller advised N24D that traffic would be departing, turning eastbound and climbing to 2,000 feet. Based on indicated data on the radar tag, the aircraft was operating under instrument flight rules; this required a minimum of 1,000 foot separation between these aircraft. Separation reduced to 100 feet, thus an operational error occurred.

Separation Conformance Distances: 100 feet/.97 miles CATEGORY A

3) February 15, 2006

TRACON management's classification: ***Pilot Deviation filed as PSWRD1006022***

AOV reviewed this event and determined an operational error occurred. Continental Airlines 215 (COA215) and American Eagle flight 845 (EGF845) were both vectored for visual approaches from the northeast. COA215 was vectored for runway 17 center (RY17C) and EGF845 to runway 17 left (RY17L) The controller cleared EGF845 for a visual approach. The controller then cleared COA215 for a visual approach and informed the pilot of the position of EGF845. COA215 did not report EGF845 in sight. Absent the pilot reporting the preceding aircraft in sight, and receiving instructions to follow, or maintain visual separation; controllers are responsible for ensuring that separation is maintained between aircraft. COA215 turned towards the airport bringing him closer to EGF845. The controller failed to ensure compliance with FAA Order 7110.65, paragraph 7-4-4.b.2. When COA215 was cleared for the visual approach, the pilot had the option to turn towards the airport and to descend, resulting in a loss of separation and an operational error.

Separation Conformance Distances: 0 ft/.64 miles CATEGORY A

U.S. Department
of Transportation

**Federal Aviation
Administration**

Office of the Administrator

800 Independence Ave., S.W.
Washington, D.C. 20591

S10-080417-004

CONTROL NO.

APR 16 2008

INFORMATION MEMORANDUM TO THE SECRETARY

From: Robert A. Sturgell, Acting Administrator
x73111

Prepared by: Shirley Miller, Air Traffic Organization
x79063

Re: Inspector General Investigative Report – Dallas/Fort Worth (DFW) Terminal Radar Approach Control (TRACON)

SUMMARY

The Office of the Inspector General (IG) has completed its investigation of the two whistleblower allegations from July 2007. The whistleblowers alleged that management at the DFW TRACON "covered up" controller operational errors by underreporting and/or failing to investigate suspected operational errors. The IG's report concludes that TRACON management misclassified incidents as pilot deviations, thereby underreporting operational errors. The IG points to deficient safety oversight processes in the Air Traffic Organization (ATO) that allowed the misclassification to occur. They also conclude that, at a minimum, there was negligent behavior on the part of TRACON management and other ATO officials and the appearance of a "cover up" at the TRACON.

BACKGROUND

The IG's report is particularly concerning because of a previous whistleblower case from 2004. In that case, the whistleblower alleged non-reporting of operational errors at DFW TRACON, which was confirmed by the IG investigation. We made changes as a result of the IG investigation, to include national policy and procedure changes and the institution of random audits system-wide. However, the latest IG investigation concludes the ATO did not follow through with implementation of the changes that were supposed to be made, particularly the random audits.

I am deeply disturbed by the findings in this report. I appreciate the employees who raised these concerns, and I am absolutely committed to implementing a voluntary reporting system so that

all ATO employees are encouraged to raise their concerns without fear of reprisal. In addition, I assure you that we are redoubling our efforts to ensure we have a robust and functioning safety oversight for DFW TRACON. We are taking steps at DFW to ensure there is no recurrence of the underreported operational errors or any other incidents that impact safety at DFW TRACON. We have already taken or are in the process of taking the following actions:

- Removed the TRACON Manager and Assistant Manager from the facility on January 22, 2008;
- Assigned an Acting Manager and Assistant Manager while we go through the selection process for permanent replacements;
- Determine appropriate administrative action for management officials involved in the underreporting of operational errors and ensure the required coordination with the Office of Special Counsel (OSC) occurs;
- Immediately begin on-site, "no notice" audits at DFW TRACON conducted by FAA's Office of Air Traffic Oversight (AOV) with monthly reports to the Acting Administrator;
- Accelerate the implementation of new automated technology (Traffic Analysis Review Program – or TARP) at DFW TRACON that detects losses of separation by the end of Fiscal Year 2008;
- Include DFW TRACON as part of the initial Air Traffic Safety Action Program (ATSAP) – a voluntary safety reporting system that is patterned after industry best practices;
- Strengthen our follow-up procedures to ensure that IG recommendations are being implemented in a timely manner; and
- We are in the process of rescinding the "Facility of the Year" award to DFW TRACON.

Although the IG has not found evidence of system wide deficiencies, we are taking the following actions to ensure we address any potential safety oversight issues:

- Establish an independent quality assurance function in the ATO Service Areas reporting to the Vice President for Safety. This function will continually oversee event reporting, make event determinations, and audit data integrity of facility reports. This will change the current event reporting process, transferring responsibility for event determination from the facility manager to this independent office for safety assurance. We will adjust our budgets to reflect an increase in staff for this function. While the quality assurance responsibility transfers to ATO Safety in the Service Area, we will continue to retain a quality control function in the facilities to ensure compliance with safety rules and regulations. After six months, AOV will formally evaluate and report on the effectiveness of this reporting and oversight process, to ensure the elimination of any conflicts of interest within the event reporting and determination process. Based on the results of the AOV evaluation and any recommendations, we will consider additional steps to improve and assure objectivity and transparency in the air traffic event reporting and determination process;
- ATO Safety Services will conduct audits of facility reports and report to the Chief Operating Officer (COO) and AOV. The ATO VP for Safety Services will be accountable for these quarterly reports;
- AOV will independently validate ATO Safety Services audit results and report quarterly to the Acting Administrator and the COO;

- A permanent VP for Safety Services has been selected and will be on board at the end of April;
- The new VP for Safety Services will be mandated by the COO to do a complete top to bottom review of ATO Safety Services to determine what additional resources are required to adequately staff and meet its investigation/audit responsibilities;
- Over the next six months, provide safety training for facility managers and safety officials on roles and responsibilities;
- Accelerate nationwide deployment of TARP to detect losses of separation at FAA's terminal facilities. Deployment to be completed by the end of calendar year 2009;
- Over the next six months, provide training for the AVS inspector workforce focused on their responsibilities for conducting investigations of reported pilot deviations. We will also ensure that the process includes a final review by ATO Safety Services when Aviation Safety investigations are completed.

In addition, we will be reviewing the events that were misclassified as pilot deviations to ensure that no pilot was adversely affected as a result.

As you know, we recently signed an agreement with the National Air Traffic Controllers Association to create the Air Traffic Safety Aviation Program (ATSAP), designed to foster a voluntary, cooperative, non-punitive environment for the open reporting of safety concerns. We will pursue a similar program with our maintenance technicians. This type of reporting system, which is in place throughout the industry, will help to create an atmosphere where controllers and managers can identify, report, and correct safety issues. This will go a long way in helping us further improve our safety record.

FOLLOW-UP

I would be pleased to meet with you to discuss additional details.

The Secretary

REVIEWED: mep

COMMENTS: _____

DATE: 4/24/08