U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505
202-254-3600

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

Summary of OSC File Nos. DI-06-1499, DI-07-2156, and DI-07-0237

Three whistleblowers employed by the Federal Aviation Administration (FAA), disclosed serious allegations concerning the air traffic operation and the mischaracterization of air traffic events at one of the nation's busiest airports, Dallas/Fort Worth International Airport (DFW), Dallas, Texas. Anne Whiteman, who consented to the release of her name, disclosed similar allegations regarding DFW in 2004. That investigation, conducted by the Department of Transportation (DOT) Office of Inspector General (OIG), substantiated the allegations and made recommendations for correcting the problems identified.[1] Ms. Whiteman later came forward with the allegations in this case when it became apparent that the underreporting and failure to thoroughly investigate air traffic events persisted. She provided new information which focused on management's misconduct regarding the characterization and reporting of those events.

Ms. Whiteman and an anonymous whistleblower alleged that FAA employees at DFW engaged in conduct which constituted a violation of law, rule or regulation, gross mismanagement, and an abuse of authority, all of which has contributed to a substantial and specific danger to public safety. The conduct identified by the whistleblowers, and detailed below, included misclassifying operational errors[2] or operational deviations[3] as pilot deviations[4] or proximity events[5], and fostering a culture and system which manipulated the reporting of air traffic events and flouted adherence to safety regulations in order to record as few operational errors or deviations at DFW as possible.

The third whistleblower, Donald Craig, a former air traffic controller at the D10 Terminal Radar Approach Control facility (D10 TRACON) until his retirement in December 2006 who consented to the release of his name, alleged that supervisors at the D10 TRACON failed to

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[1] See OSC File No. DI-04-1232.

[2] 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 Terminal Radar Approach Control facilities, the minimum Instrument Flight Rule separation standard, with some exceptions, is 3 miles horizontally or 1,000 feet vertically. DOT report p. 1, footnote 1.

[3] 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. DOT report p. 1, footnote 1.

[4] 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. DOT report p. 1, footnote 2.

[5] A loss of separation minima between two aircraft where 90 percent or greater separation is maintained in either the horizontal or vertical plane. This does not include any violation of wake turbulence separation minima or losses of separation that are classified under the No Conformance minima. FAA Order JO 7210.56C CHG 1, effective August 4, 2008.

properly report and investigate suspected operational errors and deviations as required under FAA Order 7210.56C. He also alleged that controllers were required to sign in on two automated systems in violation of FAA Order, and that a supervisor left his position on more than one occasion without designating a replacement, and was thus, unable to maintain the required situational awareness of the facility's operation.

In addition, the whistleblowers expressed concern about FAA's apparent approach to lowering the reported number of operational errors and deviations. The whistleblowers noted that since a national meeting of Facility Managers in June 2006, the use of proximity events and pilot errors and deviations had increased. This new emphasis reflected, they believed, a national policy and exposed a concerted effort on the part of FAA management to keep the number of operational errors and deviations artificially low.

Finally, the whistleblowers alleged that FAA's pay-for-performance system lent itself to the inaccurate reporting of air traffic events. Under a system which financially rewards employees when there are no operational errors or deviations, there is little incentive to accurately record those events. The allegations brought forth by these whistleblowers highlighted a pattern of persistent, dangerous management at DFW warranting further scrutiny and investigation.

The Whistleblowers' Disclosures

The Anonymous Whistleblower

The anonymous whistleblower alleged that aviation events were not properly reported as operational errors and deviations, and provided two examples. In the first, the whistleblower explained that the tower controller cleared an aircraft for departure, American Eagle 323, without first contacting the departure controller. American Eagle 323 took off and contacted the departure controller as instructed. At that point, the departure controller called the tower controller. As can be heard on the video of the incident, he asks the tower controller if he "missed something" because he did not release the aircraft for departure. The tower controller briefly acknowledged the error and the departure controller hangs up. The whistleblower stated that, at the point that American Eagle 323 crossed from the tower's airspace into the departure controller's airspace, an operational deviation occurred.

According to the whistleblower, DFW TRACON Assistant Air Traffic Manager Daniel Gutwein determined that because the exchange between the two controllers took place while the airplane was still in the tower controller's airspace, coordination within the meaning of FAA Order 7110.65 occurred. However, as seen and heard on the video clip, the controllers did not speak with each other to coordinate the departure of the airplane. The departure controller merely advised the tower controller of her mistake and abruptly ended the telephone call. The whistleblower alleged that management's conclusion was contrary to FAA Order 7110.65, Chapter Three, Section 1, which requires positive control and coordination in the management of aircraft on runways. The whistleblower believed this determination was calculated to cover-up

an operational deviation to give DFW a more favorable safety record. In addition, the whistleblower contended that interpreting the regulation in this manner sets a dangerous precedent whereby any communication between controllers and an airplane after it had already departed, without clearance from the departure controller, could be considered coordination. Finally, because the whistleblower did not recognize the operating initials of the person who completed the report, it is believed that the tower was not consulted in the final determination of whether or not tower personnel caused an operational deviation.

In the second example, the whistleblower describes an incident involving American Eagle flight 600 (EGF600) and American Airlines flight 806 (AAL806), on May 17, 2007. EGF600 was vectored to runway 17 center on a final approach course to DFW by the final approach controller at the D10 Terminal Radar Approach Control Center (D10 TRACON) and cleared for visual approach. The approach controller did not tell the pilot to contact the DFW tower; generally, pilots contact the tower controller at a distance of 5 to 10 miles out when instructed to do so by the approach controller.

The tower controller working the local control east position continued to clear aircraft for departure on runway 17 right.[6] When EGF600 was approximately two miles out from landing, the local east controller cleared AAL806 for take off on runway 17 right. The Boeing 757 produces considerable wake turbulence, therefore, aircraft are required to be a minimum of 4 miles behind the B757 and, in this case, AAL806. When EGF600 was on final approach the pilot realized that he had not been speaking to the tower. While attempting to reach the tower controller, the pilot began to execute a missed approach rather than land without a clearance.

The local control east controller had not seen EGF600 come into her airspace and had not spoken to the pilot. When AAL806 was approximately one mile south of DFW, and operating on the departure controller frequency, EGF600 flew past the tower. The controller on local control east then recognized what was happening and at that point called EGF600. The pilot was told to maintain visual separation from AAL806. The whistleblower explains that visual separation is not permissible behind a B757 or any other heavy jet departure. Further, the whistleblower notes that when EGF600 reached the departure end of runway 17 center, the airplane was 1.98 miles directly behind AAL806 and no form of approved separation existed.

DFW management officials met to discuss this incident and after reviewing the data, concluded that despite the losses of separation, there was no operational error because the local control east controller had not spoken to the American Eagle pilot prior to the loss of separation. Thus, because the tower never spoke to the pilot, the error could not be attributable to the tower, because no instructions from the tower had been given.

This conclusion appeared to violate FAA directives, including N JO 7210.633, which require positive action and hold air traffic controllers responsible for both their actions and

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[6]Runways 17 center and 17 right are 1200 feet apart. For this reason, they are considered the same runway for the purposes of wake turbulence under FAA Order 7110.65.

inactions. In the instant example, the local control east controller failed to see an aircraft entering her airspace and factor that aircraft into the management of departures on the runway she was working. While the pilot bears some responsibility, the inaction on the part of the controller and her failure to see an aircraft in her airspace resulted in a significant operational error. Management's reasoning and apparent failure to recognize these incidents as operational errors and handle them accordingly was indicative of gross mismanagement, an abuse of authority, and a disregard for public safety.

Ms. Whiteman's Disclosures

Ms. Whiteman alleged that air traffic personnel were not reporting or investigating operational errors and deviations as required by FAA Order 7210.56C. Ms. Whiteman first brought attention to the underreporting of operational errors at DFW in 2004 when she alleged that FAA personnel at DFW were neither reporting nor investigating operational errors or deviations as required. The 2004 DOT OIG investigation substantiated some of her allegations and resulted in changes to FAA Order 7210.56C to allow for the use of playback tools to investigate suspected operational errors and deviations.

As part of the 2004 investigation into Ms. Whiteman's allegations, FAA provided assurances that playback tools would be used to hold managers and ATCs accountable. Subsequently, in 2006, Ms. Whiteman alleged that despite FAA's assurances, little had changed since 2004. She reported that the system in place relied on self-reporting, and while it should work well as designed, management fostered a climate in which the reporting of operational errors and deviations was tacitly discouraged and manipulated, so that fewer errors were statistically captured. This culture of misreporting remained, thus continuing the problem.

She explained that management personnel routinely and incorrectly designated operational deviations and errors as pilot deviations. She stated that the misreporting occurred not only with the approval of officials beyond the supervisory level, but at their direction. The sharp rise in the incidence of pilot deviations at DFW was indicative of this practice. Ms. Whiteman reported that from January to July 2007, approximately 100 pilot deviations had been reported at DFW TRACON, whereas in previous years, approximately 10-20, were reported for the same length of time. She also believed that pilot deviations had increased at DFW, but not nationally. This sudden and disproportionate increase in pilot deviations at DFW suggested a pattern of mischaracterizing air traffic events.

When pilot deviations are reported, the information is transmitted to FAA's Flight Standards Division for review and any action deemed necessary. Upon landing, the pilot is notified of the deviation and can provide information to refute it. If a determination is later made that the incident is not a pilot deviation, it is not referred back to the reporting facility for a review as a possible operational error or deviation. The matter is simply dropped without further inquiry. As a result, the proper review and reporting of these air traffic events is thwarted and they are lost.

Ms. Whiteman provided nine examples of the mischaracterization of air traffic events, some of which may have been pilot deviations, but were not reported as controller operational errors or deviations. Those examples are set forth in Appendix A.

Mr. Craig's Disclosures

Mr. Craig disclosed serious allegations concerning the air traffic operation at the D10 TRACON. He alleged that supervisors at the D10 TRACON failed to properly report and investigate suspected operational errors and deviations as required under FAA Order 7210.56C. He provided five examples of aviation incidents which should have been investigated and/or reported as operational errors or deviations pursuant to FAA Order 7110.65. Those examples are set forth in Appendix B.

Mr. Craig also disclosed that at least one supervisor, Greg Hood, left his position on more than one occasion for a cigarette break without signing off from that position. Mr. Craig states that on September 8, 2006, Mr. Hood was signed onto the AS3 position from 1717Z (Zulu time) to 1812Z. During that time period, Mr. Hood left the AS3 position without signing off, and proceeded to the smoke room for a cigarette break. Mr. Craig estimated that he was away from his position for approximately five minutes. On September 22, 2006, Mr. Hood was again signed onto the AS3 position at 1330Z. Mr. Craig stated that at 1403Z Mr. Hood was observed smoking in the smoke room, but had not signed off from his position. Again, Mr. Hood was away from his position for approximately five minutes.

Mr. Craig explained that the supervisor is required to maintain situational awareness and cannot do so if absent from the operational area room. Thus, once signed onto a position, a supervisor is not permitted to leave that position without signing off or designating another qualified individual to assume the watch duties. Mr. Craig maintained that Mr. Hood's actions violated FAA Order 7210.3U, Chapter Two, Section 6, Paragraph 1a, and noted that there is a witness who can confirm these incidents.

Finally, he reported that supervisors require air traffic controllers in the D10 TRACON to sign on and off position using the Automated Radar Terminal System (ARTS) system in addition to the CRU-X/ART system. He stated that General Notice N7210.637, modifying FAA Order 7210.3, required that the CRU-X/ART system be used by air traffic personnel to sign in and out for a shift as well as on and off position because it was the official time and attendance record for position times. Mr. Craig alleged that DFW supervisors continued to require the D10 TRACON controllers to use the ARTS system and other local software to track position times of personnel in violation of the FAA Order.

Summary and Conclusion

The whistleblowers alleged that the strategy used by DFW management officials to reduce the number of operational errors and deviations was a systematic mischaracterization of air traffic events by its employees. This systemic mischaracterization gave the impression that

fewer air traffic events were occurring at DFW, adversely affected the statistical analysis of air traffic safety. In addition, it masked safety issues as well as deficits with employee and management performance and ultimately resulted in a lack of accountability for air traffic controllers and management officials.

The whistleblowers contended that these allegations exposed a continuing pattern of abuse of the protective measures meant to insulate the flying public from aviation disasters. By managing the facility in this way, DFW management's actions ran contrary to FAA's mission to "provide the safest, most efficient aerospace system in the world."[7]

The Report of the Department of Transportation

The Secretary of Transportation tasked the DOT OIG with conducting the investigation and writing the report on these allegations. The OIG assembled an investigative team comprised of senior OIG investigators, an aviation analyst/former air traffic controller, air traffic controllers, aviation experts from FAA's Air Traffic Safety Oversight Service (AOV), and a pilot from FAA's Flight Standards Service.

The investigation examined the operational errors and deviations reported by the whistleblowers and alleged to have occurred between November 1, 2005 and June 3, 2007. Investigators also focused their inquiry on all pilot deviations reported at DFW from January 1, 2006 to July 3, 2007, to determine if those events were properly classified. Additionally, the investigators reviewed pilot deviations involving losses of separation recorded at TRACONs nationwide in order to determine whether those events were misclassified, and if so, if misclassification was a national problem. Finally, the five suspected operational errors or deviations reported by Mr. Craig were also investigated. In addition to reviewing the relevant voice and radar data on these events, investigators reviewed a random sample of DFW TRACON voice and radar data for the 45-day period which preceded the OIG investigation. This review was conducted in order to ascertain whether there were additional operational errors or deviations which had not been properly reported.

The materials examined by the team included voice and radar data on the air traffic events disclosed in addition to Quality Assurance reports and any other relevant documentation. During the course of the investigation, 60 people were interviewed. Those interviewed included, among others, the whistleblowers, DFW TRACON personnel, DFW Quality Assurance staff as well as additional personnel from DFW and FAA Headquarters. A complete list of personnel interviewed can be found in the report at page 5.

The report recounts the 2004 investigation conducted into the cover-up of operational errors and deviations at DFW. Indeed, this investigation marks the second time in three years that the DOT OIG has investigated senior FAA management at DFW for irregularities regarding

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[7]Administrator's Fact Book. U.S. Department of Transportation, Federal Aviation Administration. August 2006, page 2.

the investigation and reporting of air traffic events. OIG concluded that after the first investigation found that DFW management was not properly reporting and investigating operational errors, DFW management embarked on a strategy of reporting and investigating operational errors, but in many cases, misclassified them as pilot deviations or as non-events in order to maintain a low rate of operational errors and deviations. In some instances, DFW management faulted pilots for deviations instead of assigning responsibility for an error to the controller responsible, and in cases where a pilot was properly cited for a loss of separation, DFW declined to identify the controller's responsibility in the incident. There were also some cases in which DFW incorrectly concluded that no loss of separation had occurred and declared the incident a non-event. Thus, the problem of underreporting air traffic events continued at DFW; only the manner of the underreporting had changed.

Significantly, the report states that in both investigations, OIG found that there was a lack of proper oversight within FAA. In the case of the second investigation, the report notes that failures by the local Quality Assurance personnel and the Headquarters-based Air Traffic Organization-Safety Service (ATO-Safety) allowed DFW TRACON management to continue underreporting operational errors and deviations.

Specifically, the investigation found that DFW officials misclassified 62 air traffic events, 52 controller operational errors and 10 operational deviations, as pilot deviations between November 2005 and July 2007. Of the 52 operational errors, 3 were identified as Category A, the most serious level of errors[8] and 12 were Category B errors. The investigation concluded that of the 12 suspected operational errors reported by Ms. Whiteman and the anonymous whistleblower, 10 were misclassified as pilot errors and 2 as non-events. With respect to the 5 suspected errors reported by Mr. Craig, the investigation did not uncover evidence that DFW TRACON supervisors failed to investigate those. As described more fully in the report, the investigation was unable to confirm the occurrence of some of the events due to some gaps in the information, and therefore, could not conclude that they were not properly investigated.

The investigation did conclude however, that one of the events identified by Mr. Craig was misclassified as a pilot deviation when it was an operational error. Additionally, the investigation found that the TRACON Assistant Air Traffic Manager improperly authorized controllers to follow a procedure during parallel final approaches which caused 11 additional operational errors. Due to this manager's knowledge and experience, and the obvious nature of the violation, the OIG concluded that he knew, or should have known, that he was authorizing an improper procedure.

As a result of the review into pilot deviations reported between January 1, 2006 and July 13, 2007, the investigation found that DFW had misclassified 29% of pilot deviations involving a loss of separation. For the five-month period of March 1, 2007 to July 13, 2007, investigators concluded that 25% of the pilot deviations filed by the DFW TRACON management should have

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[8]According to the report, FAA categorizes operational errors by severity with Category A being the most severe and Category D, which includes proximity events, the least severe. DOT report at p. 8, footnote 14.

been classified as operational errors. The nationwide review of TRACONs revealed a sharply lower misclassification rate of 3%. The OIG is presently conducting an audit of operational errors misclassified as pilot deviations at facilities nationwide; the preliminary evidence indicates a high percentage at DFW, supporting a conclusion that misclassification is not a national practice. The OIG's final report is expected to be completed in January 2009.

Based on the wealth of evidence collected and reviewed, the DOT's report concludes that there is compelling evidence that DFW TRACON management intentionally misclassified operational errors and deviations. The report posits that the culture at the TRACON was to avoid assigning responsibility or blame for any air traffic event to the controller. While the OIG declined to explicitly state a motive for their actions, the report finds that the circumstantial evidence indicates that DFW management achieved its goal of keeping controllers free from operational errors and deviations by implementing a systemic approach of misclassifying those events.

For instance, the report notes that the TRACON Assistant Air Traffic Manager and the Operations Manager stated that they were trying to keep controllers free from errors while operating within the rules. Their qualification notwithstanding, the DOT concluded management's conduct showed a willingness to "manipulate evidence and render unreasonable determinations favorable to controllers, but detrimental to aviation safety." DOT report at p. 10. Indeed, TRACON managers often ignored the most relevant data when investigating a suspected error or deviation or did not use the voice and radar tapes to determine whether proper coordination was established. Additionally, each of the misclassified operational errors or deviations in this case was an obvious error or deviation.

Given the experience and knowledge of DFW's senior management staff, the OIG concluded it was unreasonable to believe that those events were mistakenly reported as pilot deviations. Indeed, the report notes that during the investigation, FAA Central Region Service Center safety assurance investigators stated that the TRACON Air Traffic Manager, the Assistant Air Traffic Manager, and the Quality Assurance Manager ignored their determination that some events classified as pilot deviations were obvious operational errors. The report states that the 25% of pilot deviations declared at DFW from March to July 2007 should have been operational errors. This rate of misclassification of pilot deviations for the same period was 3%; thus DFW was misclassifying pilot deviations at a rate 8 times greater than at TRACONs nationwide. Because this misclassification rate at DFW was so high compared to other TRACONs and due to the additional evidence gathered, the OIG concluded that these misclassifications could not be attributable to mistake.

The OIG also concluded that a lack of oversight following the 2004 investigation of DFW allowed the TRACON management to continue to underreport operational errors and deviations. After the findings of the 2004 report were issued, ATO-Safety was charged with resolving the deficiencies in the investigation of operational errors and reporting at DFW TRACON. This included, in part, conducting no-notice reviews of the facility and reviewing loss of separation events. This second investigation found that ATO-Safety's last no-notice review was in June

2005. Thereafter, ATO-Safety officials reviewed random radar data from their Washington office and relied on the DFW TRACON's self-assessment of their investigation and reporting of operational errors. Not surprisingly, the facility rated itself very highly, with 100% compliance. ATO-Safety was unable to review the loss of separation events, it maintained, due to a staffing shortage prior to March 2007. The report notes that according to the current ATO-Safety investigator, that office still does not review controller operational deviations.

Responsibility for this lack of oversight lies with an ATO-Safety investigator, who later became Acting Director, and with the then-Acting Director, who later became the Acting Vice President of ATO-Safety. The investigation did not reveal any evidence that FAA senior leadership, specifically ATO-Terminal Services Vice President and ATO-Terminal Director of Safety, were aware of the misclassifications occurring at DFW. Given their leadership positions, the prior investigation, and ATO's commitment to resolve the problems identified in that first investigation, however, the DOT found that they bear some of the responsibility for the continued misconduct at the facility.

Another oversight failure occurred when the Southwest Region Flight Standards District Office (FSDO) did not independently validate the DFW TRACON pilot deviation reports. According to FAA policy, DFW TRACON is required to report pilot deviations to the FSDO for independent validation and, where appropriate, initiation of a compliance or enforcement action against the pilot. In this case, the Southwest FSDO relied many times on the TRACON's conclusion that a pilot deviation occurred, especially when the airline participated in the Aviation Safety Action Program (ASAP), a self-reporting program for pilots to raise safety concerns without the fear of being subject to an enforcement action. When an incident involved an ASAP pilot, the FSDO assumed the TRACON pilot deviation report was accurate and forwarded it to FAA's Certificate Management Office for review. If that office determined there was no pilot deviation, the matter was then dropped; it was not referred back to DFW for further review to determine whether there had been a possible controller operational error or deviation. If a pilot deviation was found, ASAP officials could take some corrective measures against the pilot.

When an event involved a pilot who did not participate in the ASAP program, FSDO officials could initiate action against the pilot. A review by AOV determined that, in this case, three pilots, out of approximately 38, received letters of warning or correction due to operational errors being misclassified as pilot deviations; no enforcement actions were initiated.

Finally, the report concludes that there is no evidence that DFW TRACON officials misclassified air traffic events in response to direction from FAA Headquarters or in response to a national FAA policy. Nor did the investigation find that FAA's pay-for-performance system was a factor in the TRACON management's pattern of misclassification.

Actions Taken or Planned by the Agency

In response to these significant investigative findings, DOT issued a number of recommendations. The report emphasizes that this is the second time in three years that an OIG

investigation has confirmed the underreporting of operational errors and deviations at DFW. Given the seriousness of the misconduct and the appearance of a cover-up of air traffic events, the OIG urged decisive action. The OIG's recommendations, made to the Acting Administrator on April 9, 2008, are summarized as follows:

1. Permanently change the DFW TRACON management;
2. Require AOV to conduct comprehensive on-site no-notice audits at DFW TRACON;
3. Expedite the early deployment of the Traffic Analysis and Review Program (TARP), scheduled to be operational at the DFW TRACON in 2011;
4. Remove the Quality Assurance function at air traffic control facilities from the supervision of the facility management due to the inherent conflict of interest in having the Quality Assurance personnel report to the facility management;
5. Conduct a comprehensive review from "top-to-bottom" of ATO-Safety's management, staffing and processes to ensure the effective internal oversight of ATO;
6. Consider appropriate administrative action for ATO-Safety officials who failed to conduct no-notice reviews after the first investigation into these allegations because that failure enabled DFW management to continue its underreporting of operational errors and deviations;
7. Consider appropriate administrative action for DFW and Dallas Love Field FSDO officials who failed to validate pilot deviations reported by DFW management officials because that failure enabled TRACON management to continue to underreport operational errors and deviations;
8. Examine the 38 TRACON identified pilot deviations reported in the investigation and where the pilot deviation is not valid, rescind any compliance or enforcement actions against the pilots and expunge their records; and
9. Reconsider DFW's award as the "Central Region Large TRACON Facility of the Year." The Vice-President of ATO-Terminal Services knew the OIG was investigating DFW at the time of the award. For this reason, the OIG comments that the award itself was imprudent.

FAA accepted the recommendations and began implementing them. A summary of actions taken by FAA follows.

Supplemental Report Received from the Secretary of Transportation

On August 13, 2008, the Secretary provided supplemental information to the Special Counsel on the status of the FAA's response to the DOT's recommendations. In her letter, Secretary Peters stated that disciplinary actions have been proposed against the officials found responsible for the misconduct at DFW TRACON. The TRACON Air Traffic Manager[9], Assistant Air Traffic Manager, and the Quality Assurance Manager, have received notices proposing their demotion to non-supervisory, non-safety, support positions, a 30-day suspension

[9]Her full title is the District Manager of the Metroplex Hub in Dallas/Fort Worth which includes responsibility for the DFW TRACON.

and a reduction in salary. The TRACON Air Traffic Manager and Assistant Air Traffic Manager have been placed on paid administration leave pending completion of the disciplinary action process.[10]

A second Quality Assurance Manager found responsible requested and received a demotion. She also received a notice proposing a 30-day suspension. The three Operations Managers identified by the report as bearing some responsibility for the misclassifications have all received letters of reprimand; two have been reassigned to other facilities. The third Operations Manager will remain at DFW. Significantly, Secretary Peters' letter states that the FAA's review of possible disciplinary actions as a result of this investigation is not yet complete. FAA continues to review the roles and responsibilities of other individuals in an effort to determine whether additional disciplinary action against managers in headquarters is necessary.

FAA has also taken steps toward implementing the other recommendations. As of April 2008, AOV began its monthly on-site no-notice audits at DFW TRACON. As of the date of Secretary Peters' letter, the results showed a significant improvement in reporting procedures and identified no issues of concern with the facility's operation. The Acting Air Traffic Manager has put in place procedural changes for reviewing operational incidents which address prior reporting weaknesses. The Secretary noted that ATO-Safety also maintains a monitoring presence at the airport.

FAA has accelerated the implementation of the TARP program. Phase I of the program was completed at DFW on September 30, 2008, instead of 2011 as originally planned. Nationwide implementation will be accelerated with completion expected by the end of 2009.

FAA is in the process of transferring the Quality Assurance function at all air traffic facilities from the supervision of the facilities to the Air Traffic Organization Services Area. This significant change will establish an independent quality assurance function that reports to the Vice President for Safety, rather than to the senior officials at the facility. Thus, the responsibility for determining whether and what type of air traffic event has occurred will lie with an independent office for safety assurance instead of the Facility Manager. FAA will continue to have a quality control function at facilities focused on compliance with safety rules and procedures. In addition, the Secretary notes that beginning in October 2008, ATO-Safety is formalizing the facility review process with quarterly reports to be sent to ATO's Chief Operating Officer (COO) and AOV. The Vice President for Safety is responsible for the reports. AOV will independently validate ATO-Safety's audit results and report on a quarterly basis to the Acting Administrator and the COO.

In response to the recommendations, ATO's Vice President for Safety is conducting a "top to bottom" review of the ATO's safety organization and functions. Upon completion of this

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[10]The FAA employees who have been disciplined in this matter are in the process of responding to the proposed disciplinary actions in accordance with their due process rights before the FAA and the Merit Systems Protection Board.

review, organizational changes designed to strengthen the investigation and audit responsibilities will be made. The Secretary stated that the review will be completed and that FAA expects to have the organizational changes fully functional by the end of 2008.

FAA has undertaken training for DFW and Dallas Love Field FSDO officials as recommended by the OIG. In addition to the aforementioned training recommended by the OIG, FAA scheduled and completed training for the entire inspector workforce.

The review of the 38 misclassified pilot deviations was underway to ensure that no pilot was adversely affected by the DFW misclassifications. According to the Secretary, the initial review indicated that a small number of pilots may have been affected. The review was to continue and any follow-up actions necessary, e.g., the rescinding of pilot deviations or expunging pilot records, were to be completed by the end of August.

FAA officially rescinded the award DFW received in April as "Central Region Large TRACON Facility of the Year." The Secretary noted that the FAA is taking a number of additional actions to address safety issues including:

- assessing the creation of an internal Oversight Office independent from lines of business;
- developing a process that analyzes hotline and whistleblower complaints to identify trends and necessary follow-up actions;
- implementing a voluntary safety reporting program in its Chicago facilities and planning to implement the program at DFW by October 31, 2008;
- conducting training and reinforcement of safety reporting procedures for ATO Facility Managers and safety officials, including a section on roles and responsibilities for reporting safety incidents, August 19-21, 2008.

The Secretary also stated that she had convened an independent panel in April 2008 comprised of aviation and safety experts to conduct a comprehensive evaluation of FAA's implementation of its aviation safety system and its culture of safety. The panel made its recommendations to the Secretary in September 2008.

Finally, the Secretary's letter concludes by stating that an initial review conducted by AOV last year and reported to the OIG found that the misclassification and underreporting of air traffic events was not a broad, systemic problem, but was limited to DFW. The Secretary reiterates that the OIG is also in the process of exploring this issue. The OIG's preliminary findings echo AOV's conclusion that the underreporting of operational errors and deviations is not occurring at facilities nationwide. The OIG's audit is expected to be completed and the final results available in early Fiscal Year 2009.

The Whistleblowers' Comments

In accordance with OSC's statute, the whistleblowers were given the opportunity to comment on the agency's initial report and on the supplemental information received. All three whistleblowers commented on the agency's initial report; Ms. Whiteman commented on the supplemental information. A copy of the whistleblowers' comments is enclosed; a brief summary is presented below.

Comments from Ms. Whiteman

Ms. Whiteman and the other whistleblowers expressed concern with FAA's apparent lack of response in terms of disciplinary action, moving people from position to position without real disciplinary action or removing them from duties and responsibilities which involve safety.[11] She also questioned whether the findings of the report have been made clear to DFW personnel. She noted that to date, the public comments of some management officials do not appear to reflect the seriousness of the OIG's findings nor that this marks the second time senior management at DFW has been found to have engaged in misconduct regarding the reporting and investigation of operational errors and deviations. Thus far, the FAA's actions have not done anything to correct the culture which encourages shifting of responsibility and cavalier actions by controllers and management. She believes that more action is necessary to increase accountability and change the operating culture of the DFW TRACON.

Ms. Whiteman takes exception to OIG statements regarding a lack of motive. The occurrence of operational errors is an indicator of problems at a facility. Hence, by artificially creating a low number of operational errors, DFW management was diverting attention from the facility. That is sufficient motivation for the misconduct. However, more important than establishing a motive is the repeated failure of FAA to hold people accountable for their continued disregard of FAA policy and procedure. The substantiation of a cover-up of operational errors for the second time in 3 years at a facility shows more intent and orchestration in the cover-up. The report confirms an overall lack of oversight by FAA. The actions proposed seems to be focused on putting more rules in place rather than enforcing the rules that are in place, ensuring people adhere to them, and holding those who do not accountable.

Ms. Whiteman also questions why no action was taken against FAA Central Region Service Center. They knew about the first investigation at DFW. In this case, they knew they were intentionally misclassifying incidents, and did not report the concerns higher up the chain of management. She points out that this is part of the overall problem with FAA oversight and wonders how this problem is being addressed.

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[11]The whistleblowers' comments predate the supplemental information received from the Secretary which describes the proposed disciplinary actions against the officials found responsible for the pattern of misclassification and underreporting of operational errors and deviations. In the supplemental information, FAA states that the two senior officials have been removed from any safety-related duties.

The OIG report finds that no one above the DFW facility knew about the misclassification and underreporting problem at DFW. However, Ms. Whiteman provides a copy of an e-mail in which Dan Gutwein, TRACON Assistant Air Traffic Manager, explains that a particular event is a pilot deviation and does not meet the criteria for an operational deviation. He also states that the incident was reviewed by DFW QA, the Terminal Area Office in Chicago, and Headquarters. The OIG investigation determined that this event constituted 2 operational errors. Ms. Whiteman posits that it may not be reasonable to say that higher management at FAA did not know there was a problem at DFW given the review and significant change in the classification of this event. Or it may be possible that Mr. Gutwein's representation of the additional reviews is inaccurate.

The report states that there was no finding that FAA senior leadership, including the ATO-Terminal Service Vice President, was aware that management at the DFW's TRACON was misclassifying and underreporting operational errors and deviations. But under the first investigation, the ATO Terminal Services Vice President was the person committed to fixing the deficiencies in operational error investigation and reporting at DFW that were the subject of the first report. For this reason, Ms. Whiteman questions the finding that no FAA senior management official was aware of the continuing misconduct.

The report concludes there was no evidence that any explicit direction was given or that there was an FAA-wide policy to cover-up or misclassify air traffic events. However, she notes that a good indication of inattention and lack of concern is shown by the absence of oversight and accountability that persisted even after the first investigation. Additionally, the sudden and sharp rise in pilot deviations, which should have been a red flag, raised no concerns about the operation of the DFW TRACON.

Ms. Whiteman submitted comments on the supplemental information provided by the Secretary. In those comments, she states that she cannot emphasize enough that the message that safety and adherence to reporting regulations is paramount is not getting through to FAA personnel responsible for ensuring air safety. Publicly, all the right statements are made. Privately, FAA personnel view any problems with safety as problems with her. She emphatically maintains that until someone has the full support of FAA and safety concerns are addressed by a cadre of personnel who share the same message, the culture will not change.

Ms. Whiteman also discusses the proposed disciplinary actions set forth by the Secretary and the FAA's own Table of Penalties. She questions why more serious disciplinary action was not taken against the senior officials found responsible for the misclassifications. She highlights the language used in the OIG's report which describes the misconduct of management officials as intentional and negligent or incompetent. Given this finding and the repetitive nature of the conduct, she believes that FAA failed to follow the guidance of its own Table of Penalties which would call for removal in this circumstance.

Additionally, Ms. Whiteman comments that despite the report's significant findings, there does not seem to be accountability for those who cover up air traffic events. She relates that even recently, after this investigation at DFW, a supervisor still chose to "roll the dice" rather

than fulfill his obligation of reporting two operational deviations. His misconduct has never been addressed and he later chose to look the other way on a possible runway incursion. The incursion was eventually investigated after an anonymous report. However, Ms. Whiteman notes that the investigation was half-hearted and quickly closed. She believes that controllers deserve better. They bear responsibility for reporting possible air traffic incidents to their supervisor, not further. Yet in that case they were questioned about what happened and why it was not reported properly beyond the supervisor.

With respect to the OIG's recommendation that the Quality Assurance function be removed from the supervision of the facility, Ms. Whiteman states that locally, the Quality Assurance Manager is still under the supervision of the Facility Manager. As such, the operational error investigation and reporting process is largely unchanged. She also believes that the random audits conducted by ATO-Safety are of limited value because the system is premised upon honest reporting. Instead, she reports that when management receives an anonymous report of an air traffic incident, they are not appalled that it was not reported, but rather, they work to justify why the event was not reported when it occurred.

Finally, Ms. Whiteman stresses that most controllers work hard and perform their duties under difficult conditions. She maintains that they deserve better from FAA management. Unfortunately, FAA does not take these disclosures seriously and she hopes that someone other than FAA is looking out for passenger safety. She states that she will continue to participate in any effort to address and fix the problems and would have welcomed the opportunity to be part of the follow-up process in this case. Indeed, she has some questions as well as answers for FAA on some of these issues in this case. Embarking on a path of disclosing cover-ups and threats to air safety by FAA officials has come at both a significant professional and personal cost over the past ten years. Nevertheless, Ms. Whiteman does not just want to point out problems, she remains willing and committed to being a part of the solution.

Comments from the Anonymous Whistleblower

At the outset, the anonymous whistleblower requests that anonymity be retained throughout this process because, despite the assurances of the Secretary and the FAA Administrator, this whistleblower believes that FAA officials would take retaliatory action forcing the whistleblower to leave FAA employment. The whistleblower notes that the report has found fault and assigned responsibility for the wrongdoing to several TRACON employees, but does not make it clear what action will be taken against those employees. In response to FAA's claims that two top managers have been removed, the whistleblower notes that both have been reassigned to the Regional Office where at least one has commented that the job is much better and pay grade is the same. The previous Quality Assurance Manager held partially responsible is reportedly working from home on a detail. The whistleblower questions the effectiveness of these "so-called" personnel actions as well as FAA's commitment to deal with those held responsible for the misclassification and cover-up of aviation incidents.

The whistleblower also comments that Paul Donaldson, Tower Manager, openly and actively operated to conceal tower events which have now been identified as operational errors and deviations, yet he is not mentioned in the report and does not appear to have been held accountable for this conduct. Additionally, the Manager for Training, Bruce Thorson, participated in "creative interpretations" of FAA regulations, yet he is not mentioned. The whistleblower states that it is unfortunate that three TRACON managers are mentioned in the report, but that only one, Ron Hathcock, was part of the group of employees trying to conceal aviation events. The whistleblower notes that the two other managers may have made mistakes but that they were not operating in concert with Mr. Hathcock. Thus, the whistleblower believes their removal would be a loss to the DFW organization.

The whistleblower maintains that to remove top managers while retaining the individuals they have hired and trained to operate as they do will do little to change the culture of deception that has grown at DFW. The whistleblower notes that FAA has badly mismanaged the air traffic system in this country. Indeed, the whistleblower believes that the system has been so mismanaged that it now stands on the verge of collapse. The whistleblower contends that FAA's ultimate goal is to contract out the air traffic control function so that the current personnel can leave federal employment and procure work with the contractors.

Finally, the whistleblower states that if no disasters occur in the coming months it is due to the dedication of the air traffic controllers. Air traffic controllers will elect retirement when possible though because of the deterioration in employee relations and civility which occurred under former FAA Adminstrator Marion Blakey. When the present population of air traffic controllers begins to retire, the whistleblower believes that air travel will be a gamble. While FAA management may make strong statements to the contrary, the whistleblower emphasizes that these same management officials repeatedly averred there were no problems at DFW, and no crisis in staffing.

Mr. Craig's Comments

Mr. Craig begins his comments by acknowledging that the lack of voice and radar data made it difficult to substantiate the examples he provided. He did provide a disc with a Camtasia recording of QAR5398. On that recording a controller stated that one of the aircraft had entered the Frisco airspace, thus causing a system deviation. Mr. Craig verbally reported this incident, but did not notice who the supervisor was because he was directing traffic. He states that an Operations Manager investigated this incident and found it to be a non-event, but he never received a copy of the QAR as required by FAA regulations. Mr. Craig questions how this event was handled because tapes were destroyed before he was provided an opportunity to review the data. Thus, when Mr. Craig was issued a letter disciplining him for his conduct during this incident, the 45-day time period had already passed and again Mr. Craig did not have the opportunity to have this incident reviewed.

The existence of the data notwithstanding, he believes the proposed disciplinary letter issued on September 3, 2006, which twice states that the LW2 controller attempted to call him,

proves the deviation. Mr. Craig reiterates that attempted coordination is just that, an attempt. FAA Order 7110.65, he states, requires coordination before the action is taken. Management did not address this event other than to discipline him for his language.

Mr. Craig also takes exception to the OIG's statements that because no records could be found regarding a report of a possible operational error on September 4, 2006, that the event, and any possible operational error could not be verified. He acknowledges that he misidentified the supervisor who was on duty. However, his allegation was that the supervisor on duty did not take the appropriate action. Further, he explains that using flight track information available on the Flight Aware website, which uses flight data from FAA's Aircraft Situation Display to Industry, he was able to plot the flight path of AWE520 onto a map of DFW TRACON's airspace. He states that plotting the aircraft's flight path in this manner shows AWE520 entering into the adjacent airspace of another controller as alleged, but it is not sufficient to determine if a separation error occurred.

Mr. Craig comments that FAA should reconsider the award given to DFW as the Central Large TRACON Facility of the Year. He also states that the financial awards received by JoEllen Casilio and Dan Gutwein during 2007, in their capacity as Air Traffic Manager and Assistant Air Traffic Manager respectively, and any Superior Contribution Increase they received in their salary should be rescinded.

Mr. Craig raised concerns regarding the personnel at the facility. As he points out, the report states that the implementation of TARP will be accelerated in order to ensure the more accurate reporting of operational errors and deviations. What is not clear, however, is that Ms. Casilio, one of the senior officials found to be responsible for the intentional misclassifications and cover-ups at DFW, is in charge of this program. Similarly, Mr. Craig states that Mr. Gutwein, found responsible for mismanagement at DFW has been placed on a team to strengthen technical training at terminal facilities.

Given the positions to which FAA has assigned these senior officials, notwithstanding their culpability for the present violations at DFW, Mr. Craig questions whether FAA intends to fix these problems, or whether the agency prefers instead to move people from one position to another to give the impression that disciplinary and or corrective action has been taken against those responsible. He comments that controllers have been fired for not reporting an operational error. He maintains that supervisors should be held to a higher standard of conduct. Moreover, those supervisors who fail to act on such a report and do not initiate a preliminary investigation have failed in both their duty and obligation. They should not be entrusted with positions of authority. In addition, unlike the approach taken by some management officials, investigations are not supposed to be punitive in nature. Instead, they are supposed to answer the following questions:

1. What caused this error?
2. Why did the pilot or controller do what they did?
3. Is there a procedure or a chart which is confusing?

4. How can this type of error be prevented?
5. What needs to be changed to prevent this type of error from recurring?

When management fails to initiate investigations into air traffic events such as those reported here, they fail to take steps which could prevent a more disastrous event from happening in the future. Mr. Craig states that it is not his intention to portray all supervisors in a negative light. At DFW, there were those who tried to do their jobs correctly. The decisions they made were often overridden by upper management at DFW or outside the facility.

In closing, Mr. Craig comments that during his career as an air traffic controller, which spanned almost 25 years, he gave the country the best air traffic service he could. There are many FAA controllers, inspectors and technicians who work very hard every day to ensure the safety of the flying public. Mr. Craig echoes comments made by James L. Oberstar, Chairman of the House Committee on Transportation and Infrastructure, and believes that FAA needs to clean house. He requests that action be taken to ensure that those responsible for the misconduct at DFW receive appropriate discipline and that FAA does indeed clean house.

Special Counsel's Comments and Conclusions

Based on the representations made in the agency reports and as stated above, I have determined that the agency reports contain all of the information required by statute and that the findings appear to be reasonable. FAA has begun to address the serious safety issues presented by these cases through its response to the findings of this investigation. The steps taken by FAA toward resolving the significant misconduct and mismanagement by its senior officials at DFW notwithstanding, it is apparent that much more remains to be done. As can be seen from the whistleblowers' comments, a pervasive culture exists within FAA that allows personnel to follow or ignore FAA Orders as they choose, and values neither accountability nor accurate reporting of air traffic events.

The whistleblowers' comments also demonstrate that FAA has, among its staff, employees committed to its successful operation and to the fulfillment of its mission to operate the safest and most efficient air traffic system in the world. To that end, I urge FAA to follow through with its stated intent to implement the OIG's recommendations, which are supported by the Secretary, and continue with its efforts to change and improve the management of the facility.

As described earlier in this Analysis, the allegations of underreporting and misclassifying air traffic events at DFW were first investigated and substantiated by the 2004 DOT OIG investigation. In response, FAA gave assurances that the misconduct and issues identified would be addressed, and the facility monitored to ensure that the underreporting did not continue. Yet, FAA failed to act and its lack of oversight is cited in this investigation as a contributing factor to the significant underreporting and misclassification of air traffic events. Moreover, in this case, the OIG concluded that senior management intentionally misclassified air traffic events to avoid attributing operational errors or deviations to air traffic controllers. In addition, the OIG also states that the prevailing culture discourages accurate reporting of those events. Indeed, the

breadth of the misconduct and underreporting has expanded in this second investigation. The problems at DFW appear to have only worsened since the 2004 investigation.

With this background in mind, I note that Congress has held a number of hearings on aviation matters in recent months. Continued Executive and Congressional attention and inquiry focusing on FAA's response to this investigation, and to investigations into whistleblower disclosures at other FAA facilities, is critical to ensure that all the corrective measures proposed are implemented and safety issues fully resolved. The history of underreporting at DFW demonstrates that without this additional scrutiny and the expectation of accountability, it is doubtful that any real change will occur at FAA.

APPENDIX A

Examples provided by Ms. Whiteman

Example 1: PSW-R-D10-05-049. EGF256, an American Airlines commuter aircraft, is in bound to runway 31R at DFW. The controller cleared the aircraft for a visual approach to the runway, but switched the aircraft to Dallas Love Tower frequency, when it should have been switched to DFW Tower frequency. The aircraft does not respond, as required. The controller failed to obtain an acknowledgement or send the aircraft to the proper frequency. The aircraft did not descend, but when the pilot realized he cannot land at DFW, he turns away from the airport, apparently flying the published missed approach procedure. When the pilot stated his intention by saying "we are going miss," the controllers recognized the situation and attempted to separate the aircraft from conflicting traffic from Dallas Love Field. The aircraft were too close together, and separation was lost. When EGF256 was turned back, there was a departure from DFW, and separation was also lost with this aircraft. At least two operational errors occurred, and possibly several controller deviations. They were not reported as such, instead, the incident was identified as a pilot deviation.

Example 2: PSW-R-D10-06-032. A departing jet, AAL704, appeared to have entered the wrong code in its transponder. A code is provided to each aircraft and identifies it on radar. An incorrect code results in radar identifying the target as another aircraft, In this case, radar identified the aircraft as CHQ6413. The aircraft departed DFW and came in conflict with MJR101, a business jet. Despite the incorrect code, AAL704 was radar identified and the controller knew the aircraft was there, but did not inform the controller working MJR101 that AAL704's transponder was set to the wrong code. The controllers were responsible for this loss of separation, but the pilot was charged because of the transponder problem. Because the rules are in place to protect the aircraft in these instances, Ms. Whiteman asserted that this loss of separation is a controller operational error, and not a pilot deviation.

Example 3: PSW-R-D10-06-060. An aircraft, N667CA, is cleared for a visual approach to Dallas Love Airport. The controller requires that the aircraft fly at the current "heading" until reaching 2,500 feet, at which point he may turn toward the airport. The clearance required the aircraft to remain on his current heading, but at 2,500 feet, the aircraft would then have been in conflict with EGF278, a commuter aircraft inbound to DFW. The pilot did as instructed, and began his turn at 2,500 feet. He was charged with a deviation. The controller is required to ensure separation, and must give a clearance that ensures that a pilot will maintain separation. Although there was a mandatory review of the pilot deviation, the controller was not charged with an operational error as the incident warranted.

Example 4: PSW-R-D10-06-066. A citation jet, FIV504, was inbound to Dallas Love Field and conflicted with EGF238, an American Airlines commuter aircraft inbound to DFW. FIV504 is approaching a point at which the aircraft should be given a turn towards Love Field, so the pilot questions whether he should turn inbound. The controller explains that he has traffic below him and at the end of the transmission gives the pilot a turn that is too little, too late.

FIV504, traveling at 260 knots across the ground, flies beyond a line that would keep him away from EGF238. The controller erred in having to be prompted by the pilot for the turn, and then used a heading that would not compensate for the aircraft's speed. The pilot was blamed for not turning quickly, but no operational error is reported as required.

Example 5: PSW-R-D10-06-071. AAL1630 was vectored to precede AAL1204 to DFW Airport. AAL1630 was turned eastbound and then the controller begins a relief briefing as he is being relieved to go home. He does not notice that AAL1204 is rapidly converging with AAL1630. By the time the relieving controller sees the conflict there is no time to react to save the loss of separation. AAL1204 was intended to be number two to the airport; instead, the aircraft arrives before AAL1630. This incident was processed as a pilot deviation, and the facility was briefed on the pilot's failure to turn quickly enough; however, the ATC's responsibility is to ensure that the headings and other instructions provided are sufficient to maintain separation.

Example 6: PSW-R-D10-60-093. The controller is working OPT704, a business jet, into Dallas Love Field, and N649WM, a small private aircraft. OPT704 is headed southwest and N649WM is headed south on a converging course. The controller descends OPT704 to 3,000 feet, as N649WM is at 3,500 feet. He needs OPT704 to descend rapidly to get below N649WM, but did not take any action to ensure that this occurred. At the last minute, the controller turns N649WM to the west to avoid OPT704. When the controller saw that the instructions he had given were not going to work, because OPT704 was not descending rapidly enough, he should have turned both aircraft away from each other, or instructed OPT704 to expedite his descent. In the alternative, he should have issued a traffic alert, to the pilots due to the possibility of collision. The mischaracterization of these types of events leads to this type of behavior.

Example 7: PSW-R-D10-07-027. COA1138 departs DFW airport and checks in with the departure controller, indicating he is climbing to 5,000 feet. He should have been climbing to 10,000 feet. The aircraft flies at 5,000 feet for quite a while, and SWA2077 departs Dallas Love Field. The two aircraft converge south of Dallas Love Airport. The controller does not notice that COA1138 checks in initially climbing to the wrong altitude, which was what caused the two aircraft to come in conflict. The controller in this example is not held accountable for missing the improper altitude. Although this might well be a pilot deviation, it is also a controller operational error. The controller is responsible for ensuring that aircraft check in or read back proper altitude clearance limits and must attempt to correct the situation.

Example 8: PSW-R-D10-07-066. A small aircraft, N8195E, is cleared for an instrument approach into Addison Airport. He cannot see the airport, so he is relying on the vectors from the controller to join the localizer, which is equipment that will guide the pilot to the ground in bad weather. The controller turns the aircraft in too close to the airport, and informs the pilot that if it does not work, he will bring him right back around for another approach. N8195E does not descend, and appears uncomfortable with the approach. He stays at 2,200 feet and comes into conflict with SWA8 inbound to Dallas Love Field at 3,000 feet. The

pilot did not err. The controller caused the loss of separation, but was not held accountable; instead, a pilot deviation was filed.

Example 9: PSW-R-D10-07-084. A Boeing 737, AAL505, is being vectored for a visual approach (meaning that at some point he will take over visually and not have to rely upon instruments or controller's vectors.) The AAL505 pilot informs the controller that he will not see the airport as there is a cloud layer obscuring visibility. The controller allows the aircraft to continue toward the airport and another aircraft, instead of realizing that the plan will not work. If a pilot is relying on instruments, the controller cannot allow the aircraft to continue toward the airport when other aircraft are in the area. The controller finally turns AAL505 out and away from other traffic, but separation was lost. Even if the pilot had turned quicker, separation would still have been lost.

APPENDIX B

Examples provided by Mr. Craig

Example 1: On July 4, 2006, Mr. Craig reported an operational deviation that occurred while he was working the Meacham North (MN) position. He explained that an aircraft, EGF682, coming in for a landing on runway 13R, announced its intention to execute a go-around. Mr. Craig stated that the controller on local control west 2 (LW2) should have notified him immediately of the go-around. Although the records indicate that the LW2 controller attempted to notify Mr. Craig within 10 seconds, the LW2 controller did not stay on the telephone line or in any other way communicate the urgency of the situation. The LW2 controller did not reach Mr. Craig for approximately one minute to alert him to the situation. In the interim, Mr. Craig was descending AAL1681 to runway 13R when he observed EGF682. He took immediate action and successfully prevented an operational error involving the aircraft, but stated that the failure of the LW2 controller to properly notify him and coordinate the aircraft constituted an operational deviation pursuant to FAA Order 7110.65, Chapter Two, Section 1, Paragraph 2-1-14. In response to this incident, Mr. Craig was disciplined for using what the agency described as inappropriate language.[12] The review concluded that there was no deviation despite the lack of coordination.

Example 2: On August 11, 2006, an AWE520 entered the Feeder West airspace without coordination from the controller. Mr. Craig stated that he prevented an operational error from occurring by redirecting another aircraft, but that an operational deviation did occur. He reported the operational deviation to Operations Supervisor (OS) Jeff Cooksey. He was later told by OS Cooksey that a pilot deviation had occurred. However, Mr. Craig stated that an operational deviation also occurred because the aircraft entered the Feeder West airspace without coordination from the Departure 3 controller as required under FAA Order 7110.65, Chapter Two, Section 1, paragraph 2-1-14a. The incident was not reported, and no action was taken.

Example 3: On September 4, 2006, Mr. Craig reported to his supervisor that during coordination with the Quitman controller regarding AAL2362, the Quitman controller stated that the aircraft had entered the Frisco airspace, which constituted an operational deviation. Mr. Craig states that no action was taken to report or investigate this incident.

Example 4: On September 4, 2006, Mr. Craig was one of three controllers working the final approach positions which use the scope to monitor air traffic. OS Cooksey was observing the traffic from the scope display used by supervisors to monitor the air operations. Mr. Craig stated that he observed an operational error occur involving a loss of separation between AAL1925 and AAL829. He reported that OS Cooksey witnessed the same incident but did not report it or take any action to investigate.

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[12] The words used by Mr. Craig were "shut up."

Example 5: On September 12, 2006, Mr. Craig observed an aircraft, N391SH, which was being vectored for Runway 36L final at DFW Airport by another controller, enter the area surrounding the Cedar Hill antenna farm located south of DFW. The aircraft was at 3000 ft. which is below the required 3500 ft minimum vectoring altitude for this area. Mr. Craig stated that this was an operational error observed by the supervisor, yet it was neither reported nor investigated.