



**U.S. Department
of Transportation**

Office of the Secretary
of Transportation

GENERAL COUNSEL

1200 New Jersey Avenue, SE
Washington, DC 20590

August 3, 2010

Karen P. Gorman, Esq.
Deputy Chief, Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036-4505

Re: OSC File Nos. DI-09-1298

Dear Ms. Gorman:

This is to follow up on your recent request for supplemental information in the above-referenced matter. Attached please find a July 30, 2010 memorandum from the Office of Inspector General, to whom the Secretary delegated the investigation. Please treat this memorandum as our supplemental report.

Please do not hesitate to contact me if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Debra J. Rosen".

Debra J. Rosen
Senior Attorney

Enclosure



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

Memorandum

Subject: **INFORMATION:** OIG Investigation
#I08E000436SINV, Re: Allegheny Flight
Standards District Office (DI-09-1298)

Date: July 30, 2010

From: Robert A. Westbrook 
Acting Assistant Inspector General
for Special Investigations and Analysis, JI-3

Reply to
Attn. of: X6-1415

To: Judith S. Kaleta
Assistant General Counsel for General Law
Office of General Counsel

This memorandum/supplemental report is provided in response to a U.S. Office of Special Counsel (OSC) email dated June 10, 2010, requesting additional information from the Office of Inspector General's (OIG) investigation into aviation safety concerns at the Federal Aviation Administration's (FAA) Alleghany Flight Standard's District Office (FSDO). We respectfully request that you forward this information to the OSC.

1. OSC Request: FAA stated, as of March 29, 2010, that it would designate a manager to determine the appropriate action, if any, regarding managers identified in the report. FAA's memorandum states that a determination is expected by May 31, 2010. Please identify the managers found to be culpable, and please provide a description of any action taken or planned as a result of the investigation, such as disciplinary action against any employee.

OIG Response: The FAA designated Deputy Director of Flight Standards Policy Oversight John McGraw to determine appropriate action of any manager identified as involved in the allegation. The managers found to be culpable are: the Alleghany Flight Standards District Office Manager; the former Alleghany Assistant Flight Standards District Office Manager; and the Front Line Manager - Airworthiness.

The Deputy Director determined that improper actions on the part of these managers constitute poor performance. Under the FAA's Performance Management System, the issues identified in the report cannot be addressed in an employee's current performance appraisal if the poor performance occurred outside the current rating

period. Therefore, the FAA determined that appropriate action in this case would constitute corrective and preventative action.

By August 31, 2010, the FAA will counsel the managers identified above about the findings in the report. In addition, FAA will provide for additional monitoring and training of the identified managers. Specifically, each identified manager will have an Individual Development Plan, the purpose of which is to ensure these managers are aware of the policies and procedures in place to prevent the identified improper actions. The Individual Development Plan will be part of these managers' performance standards. Monitoring of the Individual Development Plan will be the responsibility of FAA Headquarters management. Any deviation from policy or repetition of the type of improper actions noted in the report shall be grounds for action up to and including removal from Federal Service.

2. OSC Request: Please provide a description of any action taken or planned as a result of the investigation, such as changes in agency rules, regulations, or practices, given the seriousness and extent of the findings of violations of law.

OIG Response: The conduct discussed in the OIG investigation occurred between December 2005 and May 2009. During and subsequent to this timeframe, the FAA revised agency orders and guidelines related to compliance and enforcement to incorporate systems safety risk management principles and provide for standardization and consistency when determining appropriate enforcement action. Although these changes were part of a nationwide evaluation and not a direct result of this particular investigation, the FAA determined the revisions may have averted some of the non-compliance found in the investigation and may prevent future re-occurrence. According to the FAA, the revisions simplified the enforcement decision process, eliminated redundancies and provided for the development of guidance specific to Flight Standards.

The Orders revised were FAA Order 2150.3B, Compliance and Enforcement Program, originally revised in October 2007, and amended in October 2009, and its corresponding guidance FAA Order 8900.1, Volume 14, Compliance and Enforcement, Chapter 1 (Investigation and Compliance Related Tools), revised in January 2010. Noteworthy revisions include:

- The Enforcement Decision Tool (EDT) was replaced by the Enforcement Decision Process (EDP). The EDP corrects deficiencies in the EDT policy and its corresponding worksheet. The EDP simplifies the process, reduces redundancies, and provides examples to facilitate completion of an electronic EDP, an eight step template and worksheet used to determine appropriate action considering all of the facts and circumstances of each case.

- Whereas once the FAA determined appropriate action based on "Conduct" and "Safety Risk", the EDP now defines when legal action has to be taken as opposed to administrative or informal actions. The EDP also determines applicability of an appropriate action based on categorical exclusions and specific criteria outlined in the EPD.
- A worksheet associated with the EDP requires the signature of the investigating inspector, office manager, regional office reviewer, and regional office attorney to ensure the case has been processed in accordance with FAA procedure.
- Timeliness goals have been established for FAA investigative personnel and legal counsel's actions.
- The field inspectors and associated Flight Standards District Office no longer recommend or determine the amount of sanction to recommend for a violation. This decision is now made by the regional legal office during its review of the enforcement case.
- FAA has detailed the limitations for inspectors in performing field approvals on certain type aircraft/rotorcraft equipment and specifies those situations when a field approval or alterations must be approved by specific FAA designees, such as a Designated Engineering Representative. It also clarified those aircraft/rotorcraft systems that require approval specifically from its Aircraft Certification Office.

In addition, although not a direct result of this investigation, FAA identified a need to provide recurrent and advanced compliance and enforcement procedures training for experienced personnel. They will begin to develop this training program by the end of this fiscal year.

3. OSC Request: With regard to Allegation 5, unless otherwise answered above, please provide a description of any action taken or planned as a result of the findings that despite a well-documented history of non-compliance and the whistleblower's findings of seven violations during the inspection, these violations were not documented in the inspection.

OIG Response: The inspection noted in Allegation number 5 was a joint-inspection between the FAA and the Operator in 2007. Per FAA policy, any discrepancy noted during the joint-inspection would be allowed to be self-disclosed by the Operator, unless the violation was determined to be intentional. Although, the seven violations discovered by the whistleblower were deemed by him to be intentional, neither the OIG investigation nor the FAA Internal Assistance Capability (IAC) follow-up investigation were able to determine the decision agreed to by the whistleblower and his FAA team leader regarding the suggested disposition or processing of the

violations. Various accounts of the conversation by the whistleblower, team leader and other witnesses provided no clear account of the resulting decision. According to the team leader, the violations were to be documented as additional evidence in an EIR currently in process by the whistleblower. This action, if true, would have documented the violations. Neither the OIG investigation nor the FAA IAC investigation could validate or refute the team leader's memory regarding this issue.

The FAA intends to issue a memorandum to all its managers and employees outlining the benefit and need of utilizing its Aviation Safety Issues Reporting System. The system provides an opportunity for employees to raise an aviation safety issue to management officials at the local or national level as preferred by the employee. The reporting system has been recently placed under the FAA's Office of Audit and Evaluation. The initiative, which became operational in April 2008, provides Aviation Safety organization employees a new way to raise safety concerns if they feel they are not receiving the necessary airing or response from supervisor or management personnel.

4. OSC Request: With regards to Allegation 7, we request clarification regarding the instructions/advise received from Terry Pearsall in the FAA Headquarters Aircraft Maintenance Division, as it related to the allegation as set forth in our referral letter to Secretary LaHood dated March 25, 2009, that FAA officials engaged in an overly collaborative relationship with certificate holders, resulting in lax enforcement of aviation safety regulations. We would consider an interview of Mr. Pearsall to be necessary in this context.

OIG Response: We interviewed Mr. Pearsall as requested. At the time the allegations occurred in 2007, Mr. Pearsall served as an Aviation Safety Inspector in the FAA Aircraft Maintenance Division office (AFS-300). He has since changed positions within FAA. In 2007, Mr. Pearsall's role as an Aviation Safety Inspector was an advisory role rather than an authorizing authority. Mr. Pearsall could not recall the Multi-Function Display (MFD) issue. He could not recall any conversations with anyone about putting a placard on the MFD in the C. J. Systems aircraft. He said that his role at that time in the FAA was not as a decision maker, but as an advisor, so any "recommendation" that he might have made in this case was only a recommendation for a process to look into. He said that "limitations" placards are approved for use by the FAA. He said that it is not uncommon. He said that he may have recommended that they research the possibility of using it in this situation. He named certain things that they would have to do prior to using a placard, but said that it was certainly an avenue worth exploring. According to Mr. Pearsall, the authorizing authority would have been the Alleghany managers. Both the whistleblower and the FSDO management regarded Mr. Pearsall's information as a recommendation.

5. OSC Request: The whistleblower informed OSC that in early May 2010, an Internal Assistance Capability (IAC) team visited the Alleghany FSDO to interview individuals as a follow up to the OIG investigation. Please state whether this review is a part of any action taken or planned as a result of the investigation, and if so, please provide a description of the IAC review, the results and a copy of the report, if any.

OIG Response: As a result of the OIG Report of Investigation and findings, the Deputy Director for Flight Standards Field Operations established an IAC. An IAC is an internal independent review process to address significant or potentially significant allegations of misconduct or improper oversight. The purpose of this IAC was to assist management in making a determination of what corrective actions to take in this case. In addition, building upon the findings in the OIG report, the IAC took a broader view of the possible root causes of the aviation safety issues presented in the report. The results of the IAC will also be used to educate Flight Standards Offices, as appropriate, as a lessons learned. The IAC included interviews with Flight Standards personnel, records reviews, and an on-sight review conducted at the Alleghany FSDO in early May 2010.

The IAC agreed with OIG's findings on each of the eight allegations in the OIG report. The IAC also identified factors that may have affected or led to the improper actions by management personnel such as, the Alleghany FSDO's workload during a particular timeframe, new management personnel, and ineffective processes in conducting enforcement investigations. The IAC also analyzed FAA orders in effect at the time of the allegations and compared them to subsequent revisions to ensure deterrence of improper action such as those found in the OIG investigation in the future.