



**Federal Aviation
Administration**

**New York
Terminal Radar Approach
Control (TRACON)**

Operational Assessment

(March 2 – May 6, 2005)

June 2, 2005

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Executive Summary

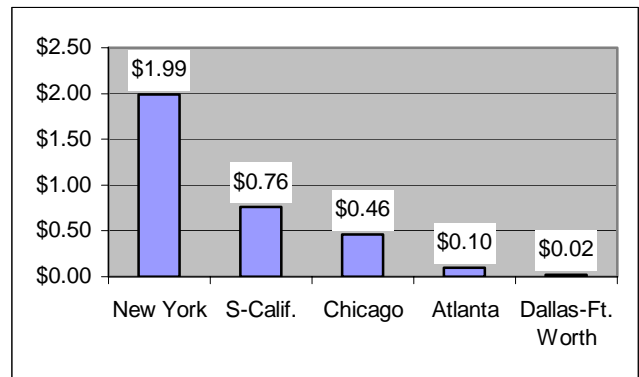
On March 2, 2005, the Federal Aviation Administration convened a team of safety experts, investigators, current and former air traffic controllers, and human resource and finance professionals to begin a 60-day on-site operational assessment of its New York Terminal Radar Approach Control (the New York TRACON) facility. The following is a summary of their findings and recommendations.

I. BACKGROUND

In the early 1990s, management at the New York TRACON entered into a series of agreements with local representatives from the National Air Traffic Controller’s Association (NATCA), the union that represents the FAA’s air traffic control workforce. By any standards these “partnership” agreements severely compromised management’s authority to set work schedules, determine staffing, and allocate overtime. As a result, at this facility, the union has enjoyed the ability to set the schedules for controller shift rotations and days off, resulting in an inefficient system that necessitates the use of a large amount of overtime.

The New York TRACON incurs by far the highest overtime costs of any large comparable facility, even though the facility has more controllers onboard and handles fewer operations per controller than most other large TRACONs. In 2004, New York spent \$4.12 million on overtime pay – more than double any other large TRACON. In comparison, Southern California TRACON handled almost 60,000 more operations yet spent \$1,628,122 in overtime. During the same time period, overtime costs per operation at Dallas, Atlanta, Southern California, and Chicago TRACONs ranged from 2 cents per operation to 76 cents. At New York, the overtime cost per operation was \$1.99.

FY04	Total Operations (IFR)	Total Controllers On board	Ops per Controller	Total Overtime
New York	2,066,708	210	9,841	\$4,122,971
Southern California	2,124,033	235	9,038	\$1,628,122
Chicago	1,502,382	74	20,302	\$696,672
Atlanta	1,386,610	69	20,095	\$148,545
Dallas Ft. Worth	1,305,622	90	14,506	\$34,829



Total Overtime Costs at Large TRACONs¹ (FY04)

Overtime Costs per Operation at Large TRACONs (FY04)

¹ In this report, large TRACON refers to Level-12 facilities handling similar traffic types & volume.

As a result of scheduling practices, 21 controllers at the New York TRACON earned over \$200,000 last year not including benefits. For 2005, approximately one out of every four controllers will earn over \$200,000². Average earnings for a controller at the New York TRACON last year were \$160,536, while controllers there guided aircraft for only an average of just three hours and 39 minutes per eight-hour shift, less than any other large TRACON. (By comparison, the average pay was \$155,068 at Southern California TRACON, where controllers worked an average of 5 hours and 6 minutes controlling aircraft.)

II. MANAGEMENT ACTIONS TO CURB OVERTIME

Lax oversight by management clearly contributed to the many problems found during this assessment. At the outset, the agency should never have signed agreements that ceded its basic rights and authorities; doing so led to wasteful scheduling practices. Moreover, local management should have been more aggressive in policing the environment at the facility. The culture that developed over the last fifteen years at the New York TRACON is thus a shared responsibility of the local union leadership and management at all levels of the FAA.

Acknowledging its responsibility, management began to take decisive action to improve oversight at the facility and eliminate waste. On June 10, 2004, management rescinded the provision in the 1998 agreement that allowed controllers to earn pre-approved “credit hours” on an unlimited basis. (“Credit hours” are extra hours voluntarily worked by controllers, who can then use them in lieu of annual leave, a practice that increases the need for other controllers to work overtime back-filling absences.) New procedures now require management approval for earning all credit hours. In September 2004, the Inspector General of the Department of Transportation issued a report that identified several areas of fraud, waste, and abuse at the New York TRACON. In response, management began contesting questionable “stress” claims filed with the Office of Workers’ Compensation Programs (OWCP) and took steps to reduce the amount of overtime. On January 18, 2005, management issued a memorandum requiring second-level approval of overtime. These memoranda are contained in Appendix 6 of this report.

Eight days after the announcement of these new overtime procedures, on January 26, 2005, the FAA began receiving numerous complaints of operational errors. These were reported anonymously to the Administrator’s Hotline, beginning on January 26, 2005. Between January 26, and March 2, 2005, eight anonymous calls alleged that previously unreported operational errors had occurred over 13 separate days. At the same time, NATCA officials publicly raised concerns that understaffing and reductions in overtime were creating an unsafe condition at the facility. Union representatives appeared on local New York television stations. A writing campaign began to pressure the agency to remove the acting manager of the facility – a long-time FAA official who was taking steps to curb unnecessary overtime.

² 50+ controllers are projected to make over \$200,000 in 2005. This amount does not include benefits; with the cost of benefits added, ___controllers are expected to make over \$250,000 at New York TRACON in 2005.

In response to the reports of operational errors and allegations of understaffing, an assessment team was assembled and placed onsite at New York TRACON. The team was comprised of air traffic personnel with experience in investigations and in facility management. It also included team members from other service areas, including human resources and finance.

On March 2, 2005, the FAA began its assessment of the facility. The on-site review lasted 60 days, and the team examined operational data, including an audit sampling of radar and voice data for the period January 31 to March 17. The team also reviewed facility scheduling practices, shift assignments, area assignments, use of leave and credit hours, assignment of overtime, time-on-position, and workers' compensation claims. Team members maintained a presence in the operating quarters of the facility, observed the control room environment, and conducted dozens of interviews with managers, supervisors, and employees. In addition, the team hired independent experts to perform studies of the staffing numbers, OWCP claims, sick leave usage, and the complexity of traffic levels at the New York TRACON.

III. FINDINGS

1. Unreported operational errors found during this assessment did not jeopardize safety.

In response to the anonymous calls to the Administrator's Hotline alleging unreported operational errors at the New York TRACON, which were first received on January 26, 2005, the team conducted an audit of both radar and voice data for the period of January 26 to March 17, 2005. The audit detected 147 previously unreported and confirmed 13 reported operational errors in three categories: failure to maintain separation on final approach, misapplication of wake turbulence standards, and failure to maintain lateral separation standards. Facility management responded immediately, ordering refresher training and increasing awareness of aircraft separation standards for all assigned controllers.

An operational error occurs when a controller fails to maintain the proper amount of space between two or more aircraft. The FAA uses a scale to determine the *potential* severity of the error. Merely because a controller has an operational error does not mean that safety has in fact been jeopardized. The majority of the errors discovered during the audit were "compression errors" on final approach, which are neither high severity nor uncontrolled violations of the separation standards. These are akin to driving 26 mph when the posted speed limit is 25. This separation standard requires controllers to keep planes three miles from each other. As a plane decreases speed on approach to the airport, trailing aircraft also must decrease accordingly. When this fails to occur in precise proportion, the line of aircraft becomes compressed, and a plane may come within 2.9 or 2.8 miles from the plane in front of it. This is counted as an error even though the operation was completely safe. In fact, in most cases, neither the controller nor the supervisor watching would be able to tell that the aircraft separation had violated the

standard, partially because there is no system that automatically flags the error - - in contrast to the high altitude air traffic control environment, where such automation exists -- and partially because the 'error' is so minor that one could not tell the difference. It is not until the radar data are collected and studied that these types of technical violations are discovered.

With the compression errors of the type detected in this audit there was essentially never any risk of collision, although the standards for separation were not rigidly followed. The team believes that this phenomena occurs at every major airport across the country. Which raises the question, if such errors occur thousands of times a year, and pose no risk to safety, why are they called errors? As a result of the findings, the FAA Administrator has asked the Air Traffic Organization to develop a sliding scale that permits variances in the separation standards during arrival phases. The team concluded that use of such a scale would be better for controllers and would allow the agency to identify actual safety risks.

The second category of errors involved misapplication of wake turbulence standards. Wake turbulence occurs when an aircraft leaves a ripple in the air similar to a speedboat's wake. This ripple has the potential to cause a problem for the pilot of the following aircraft if the plane creating the wake is a large widebody and the following aircraft is much smaller, as would be the case for a rowboat following an ocean liner. Failure to maintain wake turbulence separation accounted for the majority of Category 'A' (the more serious) and 'B' errors identified. But it is important to note that wake turbulence errors are categorized as serious because of their *potential* to cause a safety risk; the team did not find any evidence that any such errors created an actual safety concern. In fact, of the 61 wake turbulence errors, over 11 percent were attributed to the performance of just one controller, who has since been removed from his position and a suspension has been proposed. This individual will receive refresher and requalification training with an emphasis on wake turbulence separation before returning to duty.

The final category of errors, failure to maintain lateral separation standards, occurs when the projected flight paths of two or more aircraft intersect. All of such errors detected at the facility caused no risk to either aircraft. This number of moderate errors is consistent with the numbers of errors of this type found at other TRACONs throughout the system.

Of the 160 errors, 147 had not been previously reported. 79 of the errors (or almost half) occurred in the LaGuardia sector. In contrast, Newark, the busiest airspace in the TRACON, was next with 28 percent of the errors.

Management immediately imposed new requirements, including refresher training for all employees, and skill enhancement training for employees who had experienced an error. Supervisors also were ordered to be more vigilant in raising awareness of separation standards. The facility's acting manager also directed supervisors to issue on-the-spot corrections for non-compliance with air traffic protocols.

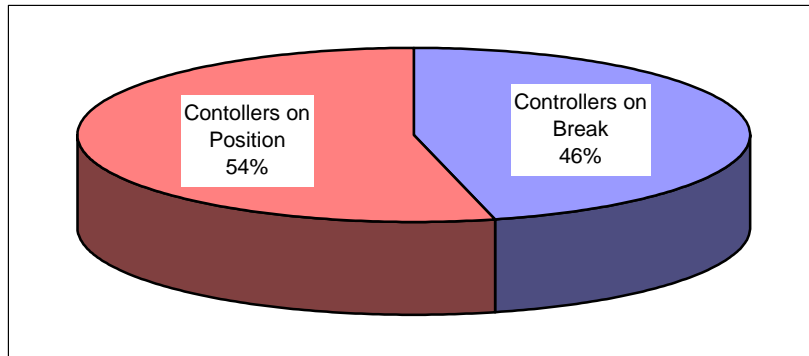
2. New York TRACON was not understaffed.

Historically, controller staffing levels at the New York TRACON have not been set according to operational standards or traffic analysis, but rather via a series of labor-management agreements, with the result that “authorized” staffing levels have no bearing on the number of controllers actually needed to safely and efficiently operate the system.

The New York TRACON is divided into five areas that correspond to the airspace around New York. Overall daily staffing levels for each area have been set according to a 1992 “partnership” accord between NATCA and management called the Facility Cooperative Team (FACT) Agreement, which are unrelated to current traffic demands and technological improvements. Through this “partnership” process, management agreed to a “three-team” scheduling approach (described in more detail below, at finding #5) that guarantees more controllers than are needed on certain weekdays, and fewer than are required on weekends, essentially dictating the constant reliance on overtime. Because of the high rate of absence (due to various forms of leave) many of the controllers at the New York TRACON actually work five days a week but are paid for six and one-half.

Importantly, the NATCA local currently controls the “watch schedule,” which sets the daily staffing requirements for each area. The schedule is generated by the union, and while it is ultimately approved by management, it has been set to adhere to the staffing levels that were agreed by the union and management in 1992. This agreement thus prevents management from making good business decisions about how to best use employees to meet traffic demands.

The team analyzed overall staffing at the New York TRACON, studied the specific staffing levels for each operational position during the time operational errors occurred, and conducted a broader review of overtime assignments at the facility. The team found that staffing was adequate to support safe operations at the facility.



Percentage of Controllers Available to Work
When Operational Errors Occurred at New York TRACON (Feb. 1 – Mar. 17, 2005)

The team also concluded that there was adequate staffing in each area when the operational errors occurred and that staffing levels did not correlate to the occurrence of

errors. On average, at the time of the errors, almost half of the controllers at the facility were not on position. In addition, the team found that the errors occurred during times of moderate traffic volume and, on average, just 29 minutes into their time-on-position, indicating that fatigue was not a factor.

The facility is currently staffed at 225, a number that is short of the 270 figure put into prior union side agreements, which NATCA now cites as evidence of “understaffing” and as rationale for more and more overtime. The team concluded that the facility is more than adequately staffed to maintain safe operations. (A recent staffing authorization by the Air Traffic Organization’s finance team called for 170 controllers at the New York TRACON once the facility controllers were scheduled properly.) In fact, the team found that on average, the time-on-position for controllers was only 3 hours and 39 minutes during an eight-hour shift. That is far less than any other large TRACON.

3. The Quality Assurance Program at the New York TRACON has not been effective.

Like other air traffic facilities, the New York TRACON has performance programs in place to correct performance deficiencies by employees. The programs provide specific direction for the reporting, investigation of, and recording of air traffic incidents. The team concluded that the programs were not being properly implemented.

The team discovered that management’s attempts to correct individual performance under these programs were met with resistance from the local union, which in years past had the backing of upper level management at headquarters. Management had little or no presence on the operational floor, and supervisory personnel routinely failed to hold controllers accountable for insubordinate or unprofessional behavior; they also did not provide on-the-spot corrections when controllers made mistakes. The team listened to controllers describe how they were threatened with loss of lucrative overtime assignments if they opposed union actions.

The team, which included human resources and organizational development personnel, conducted a separate but concurrent preliminary assessment of the environment and operating culture at the New York TRACON. Their observations and conclusions are discussed in greater depth in finding #8, on page 52.

4. New York TRACON has the highest overtime cost per operation of any large TRACON.

The team conducted a detailed assessment of the use of overtime at the New York TRACON. As the charts on the first page of the Executive Summary indicate, the New York TRACON has the highest overtime costs of any TRACON in the country. The facility’s bill for overtime -- \$4.12 million – was more than 2.5 times that of the next most costly facility.

Even though the New York TRACON has more controllers and handles fewer operations per controller, its overtime cost is more than the overtime costs at Chicago, Atlanta, Dallas, and Southern California TRACONs *combined*. The New York TRACON costs \$1.99 per operation during overtime. The cost at Chicago is 46 cents and the cost at Dallas TRACON is 2 cents.

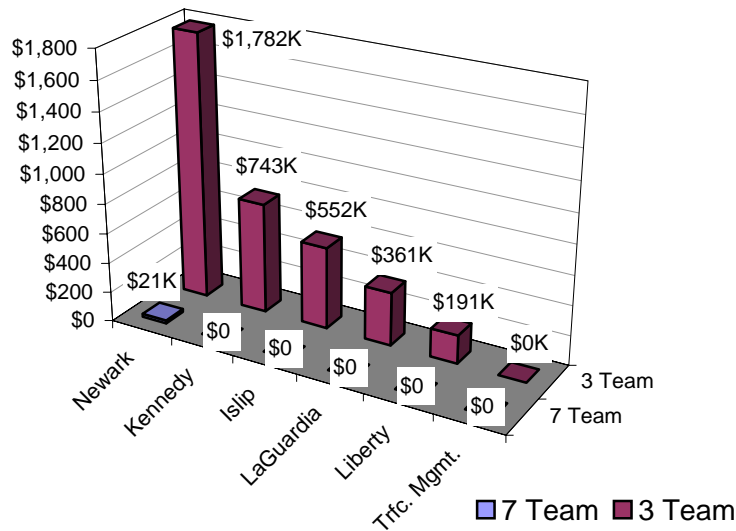
5. Current scheduling practices require unnecessary overtime to meet operational needs.

The New York TRACON uses a “three-team” scheduling system with negotiated staffing numbers that are fixed by area and divorced from actual traffic demands. Under this 3-team system, most employees have either Wednesday/Thursday, Friday/Saturday, or Sunday/Monday as regularly scheduled days off. The system produces too few controllers during peak periods of traffic. Instead of fostering efficiency, the schedule and staffing numbers trigger overtime expenditures as a matter of course. For example, under the current three-team schedule in the Newark airspace area of the New York TRACON, 16 more controllers are available to work on Tuesdays than are needed, while 10 controllers are scheduled for overtime on Saturdays and Sundays. This practice resulted in \$1,551,174 in overtime for controllers controlling traffic in the Newark area in 2004.

Areas within New York TRACON	FY04 Overtime	FY05 Overtime as of March 19, 2005
Newark	\$1,551,174	\$741,083
Kennedy	\$820,665	\$346,790
LaGuardia	\$731,741	\$532,975
Islip	\$500,011	\$221,128
Liberty	\$430,230	\$177,686
Traffic Mgmt. Unit	\$89,150	\$64,953
Total	\$4,122,971	\$2,084,615

Cost of Overtime with Current Schedule

If the New York TRACON changed from a three-team alignment to a seven-team scheduling system -- allowing for more even distribution of controllers by providing the number of controllers actually needed to cover the traffic and eliminate the need for scheduled overtime -- the FAA would save over *\$3.6 million per year*, as shown in the chart below. The seven-team schedule is currently employed at all other large TRACON facilities.



Projected Annual Overtime Expenditures at New York TRACON
Three-Team Schedule versus Seven-Team Schedule³

6. Schedule manipulation, low time-on-position, inappropriate use of sick leave, and high rates of OWCP at New York TRACON contribute to its high cost per Air Traffic operation.

Abuse of leave entitlements and schedule manipulation at the New York TRACON have dramatically increased operational costs. Specifically, the team uncovered evidence of schedule manipulation, inappropriate use of sick leave, and unusually high OWCP claim rates, all resulting in very low average time-on-position.

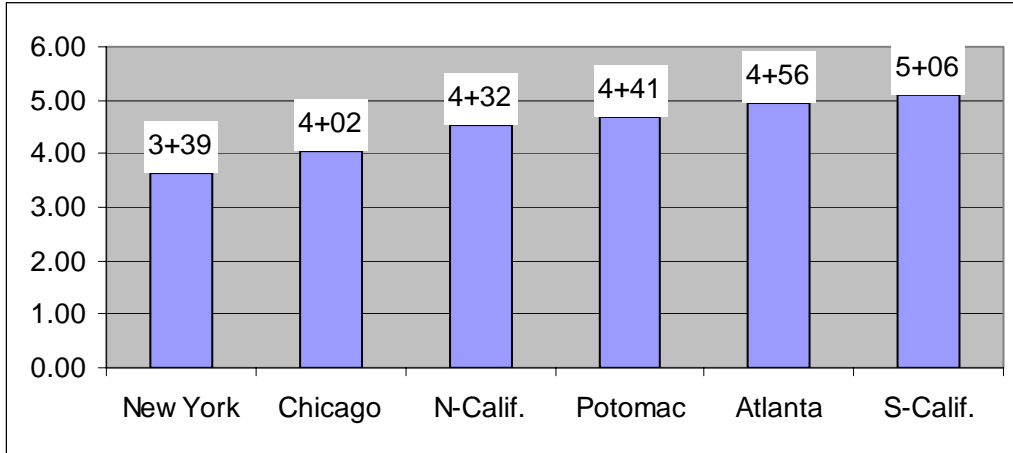
In the course of a year, the New York TRACON workforce typically uses 100 percent of the sick leave earned. Last year, absences due to use of sick leave and annual leave – and not traffic levels -- accounted for 56 percent of the facility’s overtime costs.

In addition, the team found that union control of the schedule facilitates manipulation that results in unnecessary overtime and habitual *overstaffing* of the facility. The team uncovered two examples of how such manipulation works. One controller calls in sick. Another controller agrees to come in on his/her day off to take the place of the “sick” controller. The replacement controller gets overtime, which is paid out at time and half. The replacement controller calls in “sick” during a subsequent pay period so that another controller is assured of overtime. Another pattern involves a controller showing up for work despite previously scheduled leave. Under the 1998 collective bargaining agreement, management cannot send the controller home. The controller who cancels his leave, comes in and is paid straight time. The controller that had been scheduled to replace the controller who was to be on leave now gets overtime. In subsequent weeks-

³ Projected annual overtime expenditures at New York TRACON are based on actual schedules for a single pay-period; annual totals were extrapolated for 26 pay-periods.

the controllers swap. As a result, some controllers actually only work 5 days, but are paid for 6 and one-half during a one week period.

The team also discovered that controllers at the New York TRACON typically worked less time on position -- time actually controlling aircraft -- than controllers at other large TRACONS. Again, practices put in place several years ago prevented effective management oversight of the situation. For example, most large TRACONS have an automated “sign in/sign out” tracking system that produces reports for easy monitoring. By agreement, New York uses a manual system.



Time-on-Position Per 8-Hour Shift
(FY 05 year-to-date) for Large TRACONS⁴

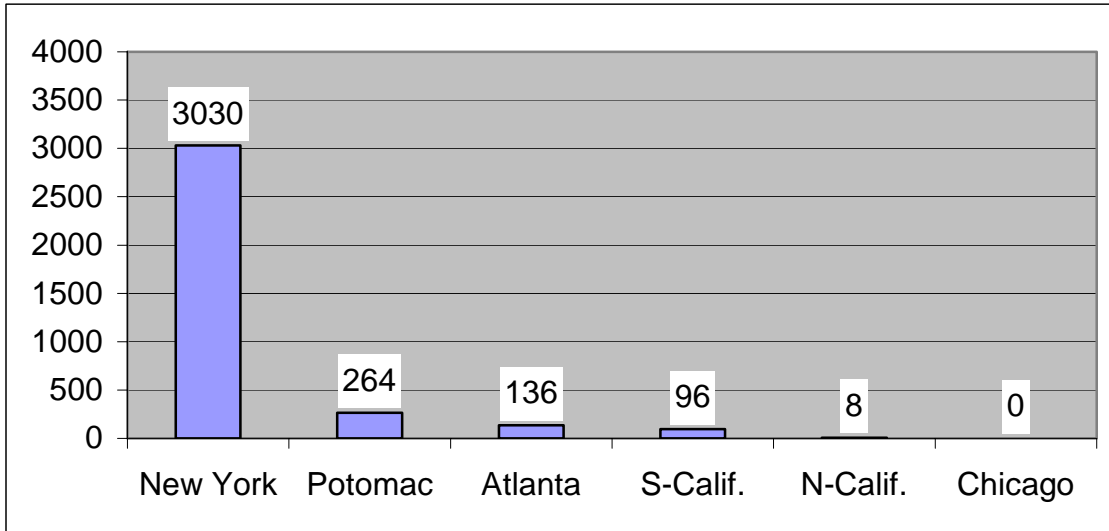
In an eight-hour shift, controllers at the New York TRACON actually spend only three hours and 39 minutes handling aircraft. In contrast, controllers at the Chicago TRACON spend 4 hours and 2 minutes working traffic in an eight-hour shift, and, at Southern California, they work over five hours. The potential for abuse is also significant. The assessment team found that individuals were “signing on” without actually working traffic. As a result on May 9, 2005, management fired a local NATCA representative for falsifying time-on-position records.

Misuse of sick leave is also apparent. The team found that controllers routinely call in sick during the scheduled five-day workweek and then show up for overtime on their scheduled day-off, thus creating an apparent sixth “work” day. The result is five workdays with a full day being paid at time-and-a-half plus the paid sick day during one week. When an individual has exhausted annual leave or is unable to get approval for a day off, some controllers call in sick.

Workers’ Compensation Claims – largely for “stress ” -- are clearly excessive. At the New York TRACON, a medical doctor’s note is not required to obtain workers’

⁴ New York TRACON data for FY 05 were not available because of the lack of automated data collection capabilities. To complete this chart, the assessment team calculated time-on-position for one week (January 23-29, 2005).

compensation. The facility lost 3,030 hours of work to such claims through the first 14 weeks of this year – the annual equivalent of four fulltime employees. In contrast, the Potomac TRACON lost just 264 hours to OWCP during the same period. In fact, the amount for Potomac, Atlanta, Southern California, Northern California and Chicago TRACONs *combined* during that period came to 504 hours, about 16 percent of New York’s total. The Chicago TRACON lost no hours during this same time period.



OWCP Hours Used at Large TRACONs
(FY 05 year-to-date)

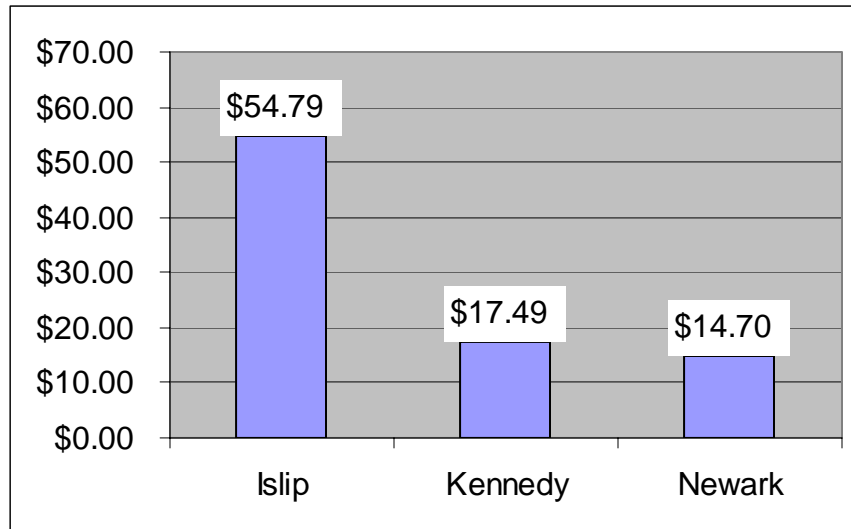
Likewise, credit hours also are the subject of abuse. In 2002, a Department of Transportation Inspector General investigation pointed to the 1998 controller agreement between the FAA and NATCA, which allowed controllers to earn unlimited credit hours without management approval. When the Acting Manager Jeff Clark rescinded this policy on June 10, 2004, credit hours earned dropped 95 percent. Credit hours drive up facility costs because they can be used much like annual leave, and thus very often require overtime to “backfill” for the controller off because of credit hours.

In 2004, another investigation by the Inspector General found overtime abuse at five locations, including the New York TRACON. When a “test” program that shifted the responsibility for approving overtime from the Supervisor to the Operations Manager was put in place, the IG was satisfied that the abuse would be curtailed. During the 10-week test, overtime dropped 21 percent at a savings of \$142,000.

7. Despite a sharp decrease in traffic counts in the Islip area staffing levels have remained constant.

Traffic counts in the Islip area have dipped from 787 per day to 523 per day. Islip originally was tasked with sequencing turbo-props from New England into the New York area airports. Largely, regional jets have replaced turboprops, and the traffic has been greatly reduced.

Because of this dip, the per-operation cost in this area has jumped dramatically and, including overtime, has reached \$54.79. For JFK and Newark, the numbers are \$17.49 and \$14.70, respectively.



Overtime Cost per Operation in New York TRACON Operational Areas

Despite the dip in traffic, staffing in this sector remains constant. Some 38 controllers remain in place to handle 33 percent less traffic. Nevertheless, overtime costs remain high, with Islip incurring \$500,011 in overtime last year.

The facility itself estimates that if the Islip Area were eliminated, an annual savings of \$8.6 million would result through normal attrition of the controllers assigned.

8. A culture of insubordination and intimidation exists at the New York TRACON that requires management attention to prevent derogation of safety.

The team included human resources and organizational development personnel who conducted a separate but concurrent assessment of the New York TRACON. The team interviewed dozens of employees, supervisors, and managers. The union refused to allow controllers to speak to members of the assessment team unless a union representative was present -- even in cases where the controller requested to do so. The team found evidence that following recent management decisions to reduce overtime and control credit hours, local union officials initiated a series of actions that were detrimental to the work environment. The team also discovered evidence of local NATCA officials engaged in physical intimidation and harassment of non-bargaining unit employees. The assessment showed a facility whose working environment could be inconsistent with safe and efficient air traffic control.

The team found that management and the local union must share responsibility for the culture that developed over the last 15 years. Management abdicated its responsibility and allowed the union control of scheduling and overtime. Management also entered into the agreements with the local union officials that resulted in the staffing levels that generate much of the overtime. Supervisors allowed lower than average time-on-position and disrespect for the separation standards. However, the team found evidence that managers or supervisors who questioned abuses -- for example, time-on-position fraud -- were subjected to intimidation and threats from the local union. The assessment team documented one event in which security was called and an especially aggressive employee was removed from the premises. Female managers felt particularly at risk. The assessment team concluded that the union fosters this environment to maintain control. Threats are tolerated and merely documented by management as a means to avoid further confrontation. The team concluded that although most controllers at the facility are cooperative, the union has neutralized the effectiveness of the supervisory workforce through threats and intimidation. Some supervisors, rather than challenging the union, simply give in to union demands.

The acting manager has been in this capacity for 18 months. Because he had taken action to reduce overtime and credit hours, and had challenged questionable OWCP "stress" claims, the local union has repeatedly sought his removal. The team found, however, that the overwhelming majority of supervisors and managers supported him.

In connection with the investigation, on May 9, 2005, management terminated a NATCA representative for falsifying official facility records, providing misleading statements in connection with an official investigation, refusing to carry out orders, and engaging in inappropriate behavior.

IV. RECOMMENDATIONS

In response to the audit's detection of numerous unreported operational errors, management immediately imposed new requirements, including refresher training for all employees. Skill enhancement training also followed for employees who had committed an error. Supervisors were ordered to raise awareness of separation standards. The facility's acting manager also directed supervisors to issue on-the-spot corrections for improper terminology and procedures.

Because the vast majority of the errors were "compression errors" that pose no risk to safety, the team recommended that the FAA reevaluate the rating system and determine whether these technical violations of the separation standard should continue to be classified as errors. The team recommended that the agency consider adopting a sliding scale with a set-minimum for separating aircraft on final approach. For the more serious errors, the team recommended that enhanced training be provided to all personnel, quality assurance programs be strengthened, on-the-spot corrections given to controllers who make mistakes, and that management should improve their oversight and presence on the control room floor.

The team concluded that the facility is more than adequately staffed and that staffing had no effect on the number of errors. It recommended that management immediately cancel the agreements that lead to the union exercising undue control over the work schedule, and adopt a seven-team schedule, which would save \$3.6 million per year by eliminating unnecessary overtime. In addition, a more rational, “seven-team” schedule would permit staffing the number of controllers actually needed to cover the traffic as well as provide a more equitable distribution of days off.

The team recommended that the FAA complete a study to implement revised staffing numbers.

In response to the extraordinary number of OWCP claims, findings of schedule manipulation, and evidence of intimidation and harassment by facility employees and local NATCA representatives, the team recommended that all relevant information be turned over to the Department of Transportation Inspector General for further review.

Finally, the team recommended several actions be taken to address its finding that as a result of recent management decisions to reduce overtime and control credit hours, incidents detrimental to the working environment have occurred involving a local NATCA officer and disruptive employees. First, management needs to take immediate action to address any threats or intimidation, and thereby recreate a professional environment in the control room. Second, management needs to take steps to restore control of resources through the daily schedule, curbing sick leave abuse, curbing excessive overtime, and establishing facility-staffing levels consistent with acceptable productivity and unit cost performance targets. Finally, the facility needs a permanent facility manager on-site.

Introduction

On June 10, 2004, management took action to reduce overtime by began to restrict overtime by rescinding the provision in the 1998 agreement that allowed controllers to earn credit hours -- which can be converted to annual leave and must be covered by back-fill overtime -- on an unlimited basis without management approval. New procedures now require management approval for earning all credit hours. In September 2004, the Inspector General of the Department of Transportation issued a report that identified several areas of fraud, waste, and abuse at the New York TRACON. As a result, management scheduled credit hours, controller's questionable "stress related" Office of Workers' Compensation Programs (OWCP) claims, and took steps to reduce the amount of overtime. On January 18, 2005, management issued a memorandum requiring second-level approval of overtime. These memoranda are contained in Appendix 6 of this report.

Eight days after the announcement of these new procedures on January 26, 2005, the FAA began receiving numerous complaints of operational errors. These were reported anonymously to the Administrator's Hotline, beginning on January 26, 2005. Between January 26, and March 2, 2005, eight anonymous calls alleged unreported operational errors over 13 separate days. At the same time, NATCA officials publicly raised concerns that understaffing and reduced overtime were creating an unsafe condition at the facility. Union representatives appeared on local New York television stations. A writing campaign began to remove the acting manager of the facility – the manager that was taking steps to curb unnecessary overtime.

In response to the reports of operational errors and allegations of understaffing, an assessment team was assembled and placed onsite at New York TRACON. The assessment team was comprised of air traffic personnel with experience in investigative assessments, and facility management. It also included team members from other service areas, and personnel from human resources and finance.

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Facility History

New York TRACON, located in Westbury, New York, was the first consolidated approach control facility in the nation. In the late 1960s, the three TRACON facilities serving Kennedy, LaGuardia, and Newark airports were consolidated into the New York

Common Instrument Flight Rules (IFR) room (also known as the Common-I) located in Hangar 11 at Kennedy Airport. The Common-I was renamed New York TRACON and moved to its current location in 1981. During the early 1980s, New York TRACON expanded with the addition of Islip and Westchester approach controls. At the time, the workload was divided among four Areas of Specialization: LaGuardia (LGA), Kennedy (JFK), Islip (ISP), and Newark (EWR). In 1987, the Liberty (LIB) area was added as part of the Expanded East Coast Plan. New York TRACON expanded once again in 1990, when the facility incorporated approach control functions for the Mid-Hudson region.

The airspace encompasses almost 19,000 square miles from the surface to 17,000 feet. Class B, Class C, and tower en route air traffic control services are provided using the Automated Radar Terminal System III computer system on 35 radar displays. Radar data is received from five remote surveillance sensors (Newark, White Plains, Islip, Kennedy, and Stewart).

Daily operations average between 6,000 and 7,000, with a peak count of 7,879 operations on June 30, 2000. The total annual traffic count for CY 2004 was 2,066,730 operations.

Operational Error (OE) Background Information

An operational error occurs when a controller fails to maintain the proper amount of space between two or more aircraft. The FAA uses a scale to determine how 'significant' the failure or error is. Just because a controller has an operational error does not mean that safety has been jeopardized. Standard separation is specified in FAA orders, and there are several methods for identifying and reporting OEs in terminal airspace.

1. Normally, an OE is reported by controllers, supervisors, or flight crews. When flight crews or controllers believe that a separation standard has been violated, or otherwise believe that an incident is considered to be unsafe, preliminary information is reported directly to facility management.
2. Flight crews occasionally report occurrences to airline and/or flight crew union representatives, who then notify FAA facility management. For example, on rare occasions, flight crews receive a Traffic Alert and Collision Avoidance System (TCAS) Resolution Advisory (RA), which consists of a visual indication and a simultaneous automated audio instruction to climb or descend to avoid a potential midair collision.
3. In some cases, initial reporting is made through confidential reporting channels, such as the Department of Transportation (DOT) Office of Inspector General (OIG) and FAA Administrator Hotlines, the National Transportation Safety Board, or a user's flight department.

For en route facilities, a tool has been incorporated that automatically identifies a loss of separation. This tool is known as the Operational Error Detection Program (OEDP). Due to multiple separation standards within the terminal environment, no such automated tool has been developed. The FAA relies on controllers and management at terminal facilities to report such incidents.

When a determination is made that an OE has occurred, the FAA uses a rating system to determine how significant the operational error is – known as the Severity Index. This Severity Index was developed in 2000 by FAA Air Traffic Services to provide a more complete analysis of each error, and to help assess the extent and type of training that should be provided to the involved controller(s). The Severity Index Chart, attached as Appendix 2, contains the criteria used to determine the severity regarding variance from separation standards for operational errors.

The rating system employs four categories: Category A events are rated as high severity errors; Category B events are moderate-uncontrolled errors. Classification of an error as uncontrolled results when the investigation indicates the controller was unaware of the impending conflict and did not take timely action to mitigate the loss of separation. Category C events are moderate-controlled errors, and Category D events are rated as low severity errors.

The Severity Index was designed to assess the variance from required separation, and it is not directly related to the risk of collision. One of the concerns with the current metric is that there is subjectivity associated with ascertaining the level of the controller’s awareness and action when categorizing errors as “controlled” or “uncontrolled.” Thus, the classification of an error as either Category B or C can be arbitrary.

Methodology

The team’s first priority was to examine operational data covering the time periods associated with the Hotline complaints. In conjunction with this review, the Air Traffic Organization (ATO) initiated an audit of radar and voice data. Initially, the scope of the audit was limited to seven days based on a selection of individual radar positions and hours of the day. This audit revealed additional OEs, which had not been previously reported. Upon discovery of these OEs, the ATO initiated an audit of radar and voice data (45 days), which covered the time period between February 1, and March 17, 2005. The audits were conducted to look for unreported OEs during this timeframe.

Team members maintained a presence in the operating quarters throughout the assessment to observe first-hand the control room environment and the effects of facility scheduling practices. Information that became available during this analysis led to further examination of facility shift scheduling practices. The team also collected and analyzed data that pertained to operational staffing impacts on safety at New York TRACON. This analysis includes reviews of facility scheduling practices and factors that influence the availability of human resources. These include personnel available to the operation, shift assignments, area assignments, use of leave, time lost to OWCP claims, assignment of overtime, assignment of other duties, and time-on-position data.

ATO also engaged the services of independent experts to perform external studies of traffic staffing and complexity at New York TRACON.

The findings are grouped in three broad areas: System Safety, Resource Management, and Organization Culture.

System Safety

Finding #1: Unreported operational errors found during this assessment did not jeopardize safety.

In response to the anonymous calls to the Administrator's Hotline alleging unreported operational errors at the New York TRACON, which began on January 26, 2005, the team conducted an audit of both radar and voice data for the period of January 26 to March 17, 2005. The audit revealed 147 unreported and 13 reported operational errors in three categories: failure to maintain separation on final approach, misapplication of wake turbulence standards, and failure to maintain lateral separation standards. Although there are no reports of pilots taking evasive action or reporting a near miss related to the 160 errors, facility management responded immediately, ordering refresher training and increased awareness of separation standards for all assigned controllers.

The team commenced initial investigations as required by FAA Order 7210.56 to determine whether corrective action was needed to maintain system integrity. The investigations specific to the losses of separation covered a 45-day period between February 1, and March 17, 2005, and included review of more than 240 hours of radar/voice replay. The method for choosing the 240 hours for review is included in Appendix 3.

As a result of the analysis of Hotline calls and data received from other sources⁵, the team identified 61 OEs that had not been reported at the time of occurrence. These errors were in addition to OEs that were identified and reported through normal channels during the period of this assessment.

Between January 26 (the first Hotline call), and March 17, 2005, the total number of investigated incidents determined to be OEs was 160. The assessment team uncovered 147 unreported OEs during the 45-day assessment period. As stated in this report, the team identified OEs as a result of Hotline calls that had not been reported through normal channels. In addition, the team conducted an expanded audit, and identified additional OEs that occurred between January 5 (21 days before the first Hotline call), and March 17, 2005 (15 days after the last Hotline call). These OEs had not previously been reported. Although many of these errors were low in severity, the TRACON is required by FAA orders to report them. Failure to report OEs impedes the FAA's ability to improve facility safety and air traffic controller performance. These errors were discovered as a result of information from three sources: errors reported by the facility during the investigation period, errors discovered as a result of the Hotline calls, and errors discovered as a result of an expanded 45-day audit conducted by the assessment team. The errors were then classified by one of four severity rating categories (A, B, C, and D). This breakout is shown in Figure 1 below.

⁵ Other sources include airlines, adjacent facilities, and pilot reports.

SOURCE	ERRORS	CAT. A	CAT. B	CAT. C	CAT. D	Non Severity (N/A)	% of Total OEs
Facility-reported	13	0	7	4	1	1	8%
Hotline investigation	58	11	6	28	8	5	36%
Other ⁶	3	0	2	0	1	0	2%
45-day audit	86	7	9	57	12	1	54%
TOTAL	160	18	24	89	22	7	100%
PERCENTAGE	100%	11%	15%	56%	14%	4%	

Figure 1. Sources of OEs at New York TRACON

Note: Severity ratings are subject to the normal review process that will occur as the final OE investigation reports are completed.

OEs occurred in four of the five operational areas in New York TRACON (LGA, EWR, JFK, and LIB), as shown in Figure 2, below.

AREA	CAT. A	CAT. B	CAT. C	CAT. D	Non Severity (N/A)	TOTAL	% of Total OEs
LGA	3	14	43	19	0	79	49%
EWR	2	4	35	3	0	44	28%
JFK	13	4	11	0	7	35	22%
LIB	0	2	0	0	0	2	1%
TOTAL	18	24	89	22	7	160	100%
PERCENTAGE	11%	15%	56%	14%	4%	100%	

Figure 2. OEs at New York TRACON by Area

⁶ Two incidents involved phone calls from Newark Tower and the New York TRACON NATCA Local representative. The third incident involved an email from an air carrier.

OEs were also divided into three types (wake turbulence, final compression, and crossing traffic). The breakout by operational area is shown below, in Figure 3.

AREA	FINAL COMPRESSION	WAKE TURBULENCE	CROSSING	TOTAL	% of OEs
LGA	49	10	20	79	49%
EWR	14	25	5	44	28%
JFK	7	26	2	35	22%
LIB	0	0	2	2	1%
TOTAL	70	61	29	160	100%
PERCENTAGE	44%	38%	18%	100%	

Figure 3. OEs at New York TRACON by Area and Type

These types of errors were divided over the four severity categories, as shown in Figure 4.

ERROR TYPE	CAT. A	CAT. B	CAT. C	CAT. D	Non Severity (N/A)	TOTAL	% TOTAL
CROSSING TRAFFIC	0	14	14	0	1	29	18%
FINAL COMPRESSION	0	4	39	22	5	70	44%
WAKE TURBULENCE	18	6	36	0	1	61	38%
TOTAL	18	24	89	22	7	160	100%
PERCENTAGE	11%	15%	56%	14%	4%	100%	

Figure 4. Error Types at New York TRACON by Category

Errors rated Category A or B differed in type between the operational areas, as depicted in Figure 5 below. In the JFK area, the majority of Category A and B errors resulted from misapplication of wake turbulence separation standards. In the LGA area, the majority of the Category A and B errors resulted from inappropriate spacing on the downwind portion of the approach. The EWR area had fewer Category A and B errors than the LGA area, and the six errors that did occur were evenly distributed between wake turbulence and final approach compression. The LIB area had two Category B errors, both involving aircraft on crossing courses.

AREA	WAKE TURBULENCE	FINAL COMPRESSION	CROSSING TRAFFIC	TOTAL	% A/B
LGA	5	3	9	17	40.4%
EWR	3	0	3	6	14.2%
JFK	16	1	0	17	40.4%
LIB	0	0	2	2	5%
TOTAL	24	4	14	42	100%
PERCENTAGE					
	57%	10%	33%	100%	

Figure 5. Category A and B OEs by Area and Type

Final Compression

An operational error occurs when a controller fails to maintain the proper amount of space between two or more aircraft. The FAA uses a scale to determine how ‘significant’ the failure or error is. Just because a controller has an operational error does not mean that safety has been jeopardized. For example, the majority of the errors discovered during the audit were known as “compression errors” on final approach, which are not high severity or uncontrolled violations of the separation standards. These are in many cases akin to driving 26 mph when the posted speed limit is 25. This separation standard requires controllers to keep planes three miles from each other. As a plane decreases speed on approach to the airport, trailing aircraft also must decrease accordingly. When this fails to occur, the line of aircraft becomes compressed, and a plane may come within 2.9 or 2.8 miles from the plane in front of it. This is counted as an error even though the operation is completely safe. In fact, in most cases, neither the controller nor the supervisor watching would be able to tell that the aircraft violated the standard, partially because there is no system that automatically identifies the error - - as is the case in the high altitude air traffic environment and partially because the ‘error’ is so minor that you virtually could not tell the difference. It is not until the radar data are collected and studied that these types of technical violations are discovered. With the compression errors identified in this assessment there is virtually no risk of collision, although the standards for separation were not adhered to. The team believes that this occurs at every major airport across the country. Which raise the question, is these types of errors occur thousands of times a year, and pose not risk to safety, why are they called errors? As a result of the findings, the FAA Administrator has tasked the Air Traffic Organization with developing a sliding scale that permits variances to the separation standard during arrival phases without incurring safety risks. The team concluded that such a variance would be better for controllers and better for efficiency.

Wake Turbulence Separation Minima

The second category of errors involved misapplication of wake turbulence standards. Wake turbulence occurs when an aircraft leaves a ripple in the air similar to that of a speedboat’s wake. This ripple has the potential to create a problem for a pilot if the plane

creating the wake is a large widebody and the following aircraft is much smaller, as would be the case for a rowboat following an ocean liner. Failure to maintain wake turbulence separation accounted for the majority of Category ‘A’ (the more serious) and ‘B’ errors identified. It is important to note that wake turbulence errors are categorized as serious because of their *potential* to cause a safety risk; the team did not find any evidence that any such errors created an actual safety concern. Ten percent of Category A and B errors involved compression. In fact, of the 61 wake turbulence errors, over 11 percent were attributed to the performance of just one controller, who has since been removed from his position and suspended. This individual will receive refresher and requalification training with an emphasis on wake turbulence separation before returning to duty.

Crossing Traffic

The final category of errors, failure to maintain lateral separation standards, occurs when the projected flight paths of a pair of aircraft intersect. All of these errors caused no risk to either aircraft. This number of moderate errors is consistent with the numbers of errors of this type found at other TRACONS throughout the system. Thirty-three percent of Category A and B errors involved crossing traffic. Of the 29 errors attributed to failure to maintain lateral separation, 14 were judged to be Category C, moderate-controlled. The number of errors in this category is consistent with other terminal facilities in the NAS.

Error Reporting

Based on recent discoveries by the Department of Transportation (DOT) Office of Inspector General (IG), the assessment team believes that OEs are being under-reported at multiple facilities because there is currently no automation in terminal facilities to detect errors. New York TRACON does not report all of the OEs that occur within the facility’s airspace.

FAA regulations require all FAA air traffic controllers to report to facility management any incident in which a controller believes that a separation standard has been violated, or otherwise believes that an incident is considered to be unsafe. Management then investigates the incident and determines if an OE has occurred. For en route facilities, a tool has been incorporated that automatically identifies a loss of separation. This tool is known as the Operational Error Detection Program. However, due to multiple separation standards within the terminal environment, no such automated tool has been developed. Therefore, the FAA relies on controllers and management at terminal facilities to report such incidents.

The DOT IG recently issued a report on the failure to report OEs.⁷ When the assessment team arrived at New York TRACON, it determined that an expanded audit should be conducted to determine if underreporting of OEs was a problem.

⁷ “Audit of Controls Over the Reporting of Operational Errors,” Report Number AV-2004-085, September 20, 2004.

Although most of the errors were low in severity, FAA rules currently dictate that *every* mistake must be reported, regardless how minor it may be. While it is difficult to determine why controllers do not report errors, the team suggested three reasons: (1) controllers don't always know an error has occurred; (2) there is no incentive to report the error or penalty for not reporting; and (3) there's insufficient training and emphasis about why errors should be reported.

Management Response

In response to the Hotline calls and the initial findings of the assessment team, management at New York TRACON initiated actions as described below.

1. Training. The facility initiated three separate training activities.
 - a. Refresher Training for All Employees. All employees were required to complete a training video that reinforced wake turbulence separation standards and to complete a course that emphasized final approach separation standards. The training commenced on March 11, 2005, and as of May 3, all but four employees had completed the training. Training and awareness appear to have had a mitigating effect as the number of OEs declined by the end of the assessment period.
 - b. Refresher Training Laboratory. All employees assigned to the EWR, LGA, or JFK operational areas are required to complete laboratory training on final vectors. The training will involve scenarios on radar equipment with aircraft to provide practice for controllers on final vectoring to separation standards. The training began on May 2, and will be completed within six months.
 - c. Skill Enhancement Training. All personnel who were associated with one or more OEs are required to complete additional skill enhancement training, which is tailored to each error and employee. Skill enhancement is now being finalized for each of the 160 errors.
2. Awareness. The facility took the following actions to raise awareness about required separation standards.
 - a. On February 11, the Acting Air Traffic Manager (ATM) issued a memorandum to all employees reaffirming the requirement to maintain separation standards.
 - b. The facility provided mandatory briefing items in February and March involving reporting requirements and separation standards.
 - c. The Acting ATM directed supervisors to be more vigilant with traffic on final approach and to ensure all handoff positions were staffed when practical.
3. Performance Management
 - a. The Acting ATM directed supervisors to issue on-the-spot corrections for non-compliant activities (e.g., incorrect phraseology and/or procedures, disruptive behavior in the control-room environment).

- b. The Acting ATM directed Operations Managers (OMs) to ensure that all evening shifts (which have the heaviest traffic demand) are staffed with a supervisor in each area (rather than a Controller in Charge).
4. Procedures and Coordination
- a. New York TRACON submitted a request to change the Maspeth Climb so aircraft would turn based on Distance Measuring Equipment instead of altitude.
 - b. New York TRACON coordinated with Flight Procedures, Flight Standards, the Teterboro Users Group, Regional Office personnel, and System Operations personnel to address pilot confusion with the Teterboro 5 Departure Procedure.
 - c. New York TRACON coordinated with lower level satellite towers for their assistance with ensuring auto-acquisition of IFR departures.
 - d. New York TRACON coordinated with all tower managers in the area to seek their assistance with separation on the finals, particularly JFK, EWR, and LGA.
 - e. New York TRACON reviewed Letters of Agreement with tower managers to ensure mutual understanding of separation responsibility on the finals in tower airspace.

LGA Operational Area

The LGA area logged more OEs than any other area, accounting for 49 percent of the errors at New York TRACON and 40 percent of the Category A and B errors at the facility. LGA documented OEs of all three types, but the majority of LGA errors (62 percent) were compression errors on final approach. Overall, LGA errors declined slightly by the end of the assessment period, with the exception of five errors committed on March 11, 2005. These five errors occurred within three minutes and were all associated with the same controller. The error sequence is depicted in Figure 6 below.

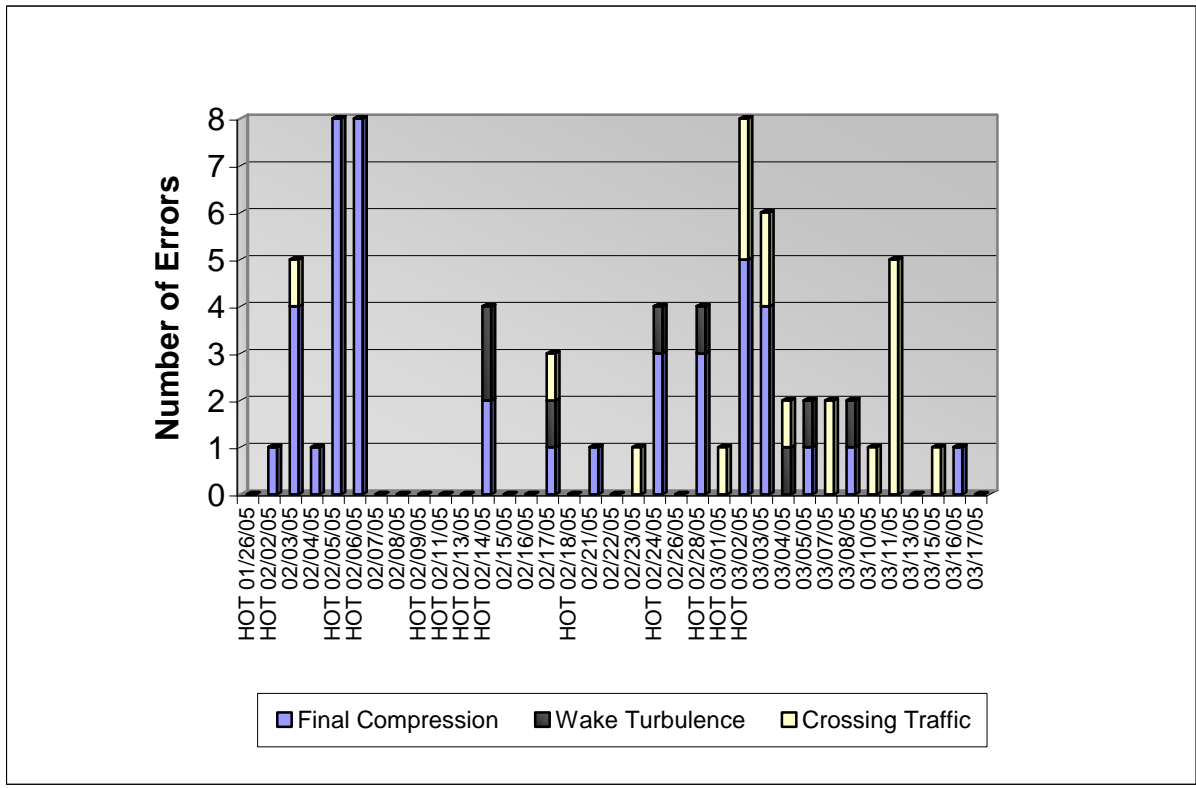


Figure 6. LGA Area OEs by Occurrence

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

LGA Category A or B errors were mostly lateral separation (nine) or wake turbulence separation errors (five). These errors increased slightly toward the middle of the evaluation period before decreasing, as defined in Figure 7. Of all LGA OEs, the closest proximity involved lateral separation (crossing) traffic with the pair of aircraft at zero feet vertical and 1.59 miles lateral.

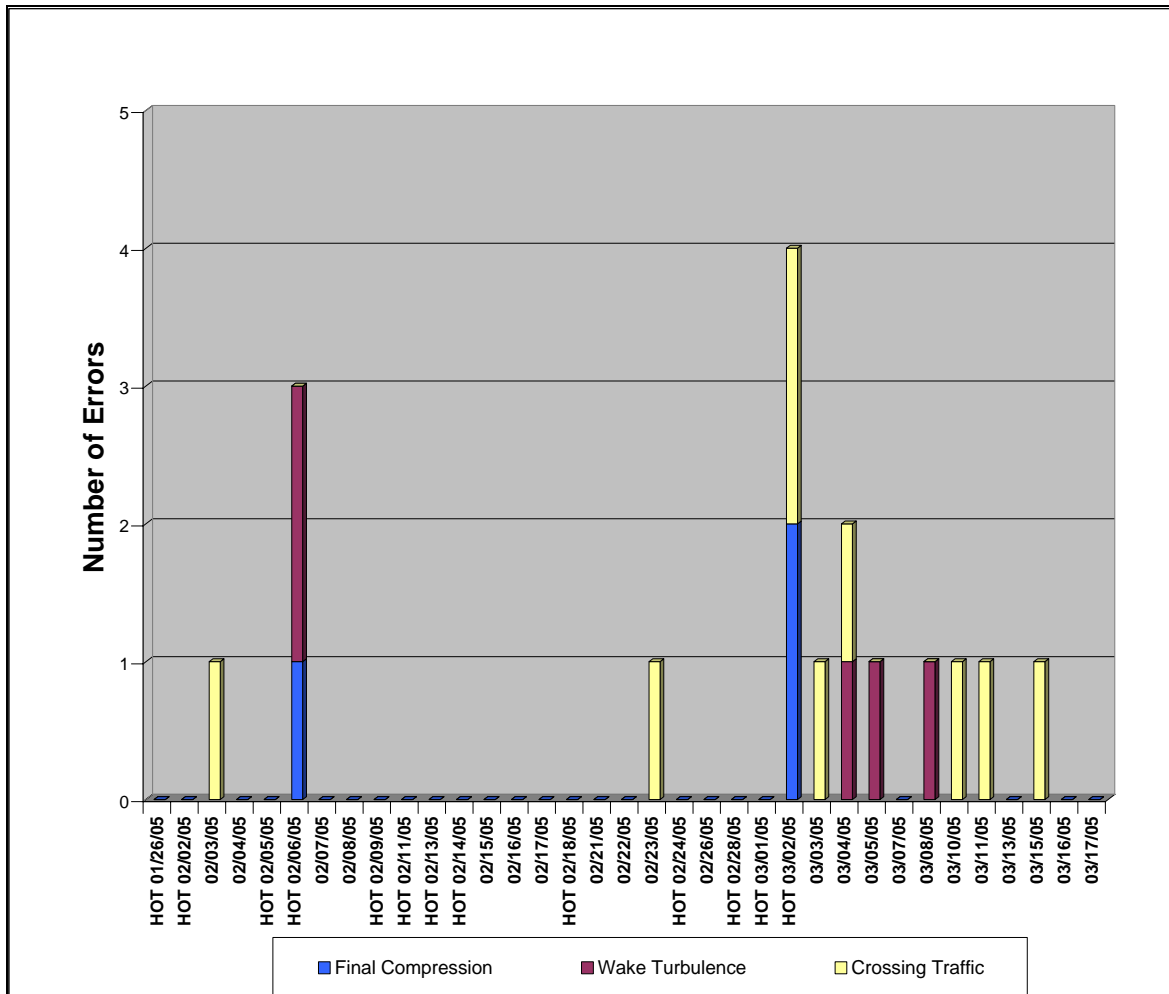


Figure 7. LGA Area Category A and B Errors by Occurrence

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

EWR Area

Although the EWR operational area has the highest volume of traffic of all the operational areas, the EWR operational area accounted for only 28 percent of all errors at the facility and for 14 percent of Category A and B errors. The majority of EWR errors (57 percent) were caused by failure to apply wake turbulence separation standards, and 32 percent were final approach compression errors.

Errors in the EWR area declined significantly throughout the assessment period, as shown in Figure 8 below. Of the 44 total errors in the assessment period, only two occurred after March 2.

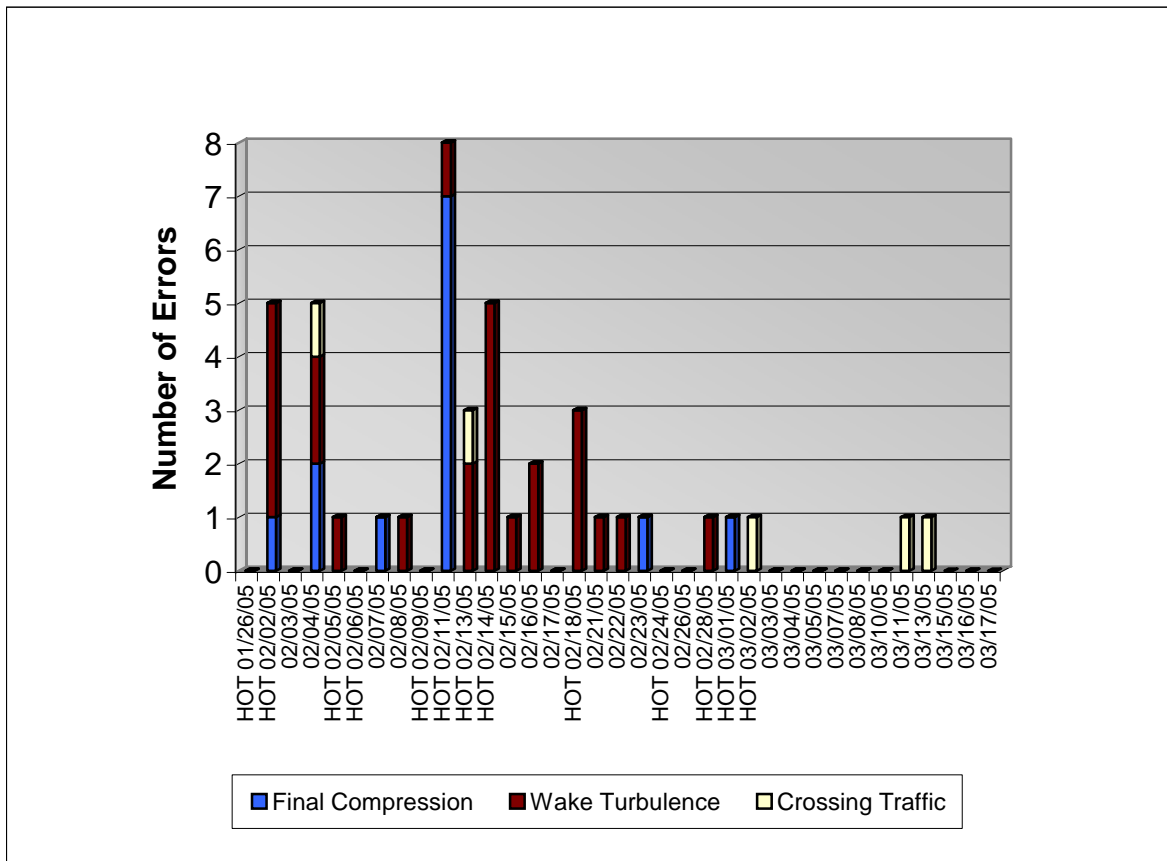


Figure 8. EWR Errors by Occurrence

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

EWR had six errors rated Category A or B. Three were wake turbulence and three involved aircraft whose flight paths were projected to cross. These errors also decreased during the evaluation period, with only one error occurring after March 1. This breakout is shown in Figure 9 below. Of all EWR OEs, the closest proximity involved crossing traffic with the pair of aircraft at zero feet vertical and 1.43 miles lateral.

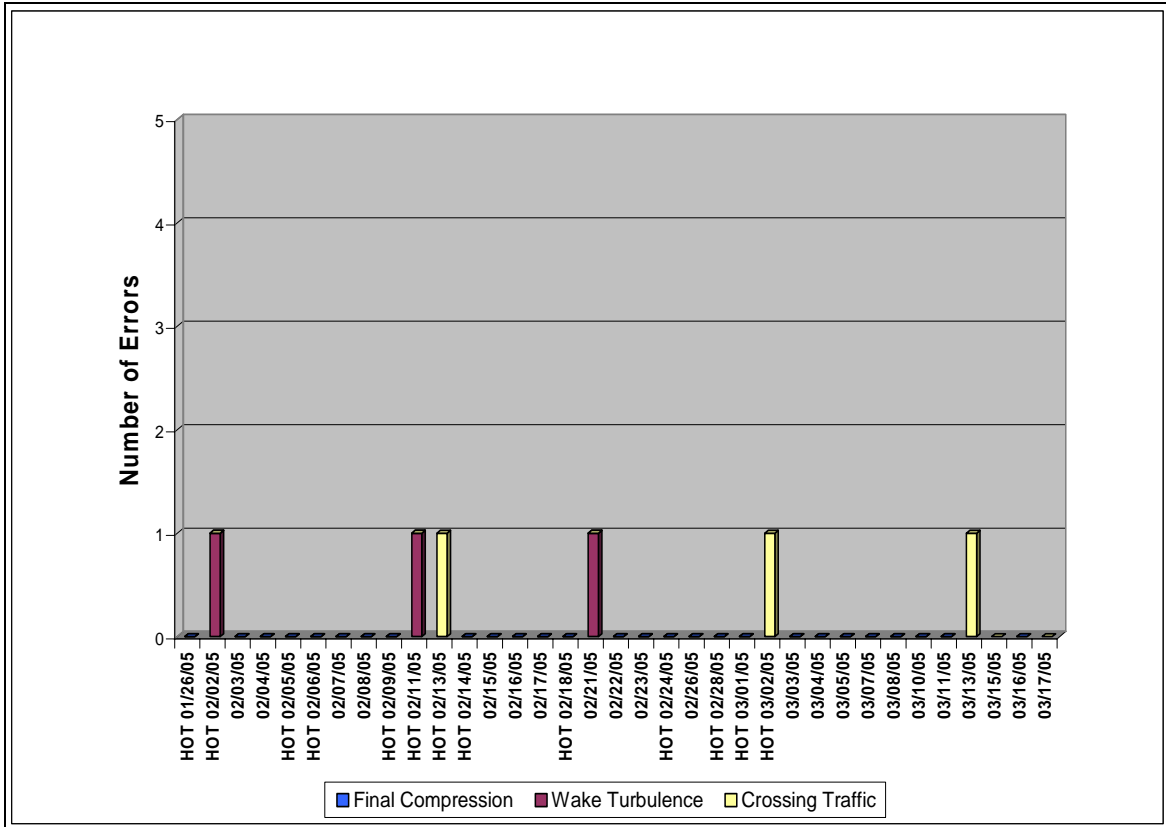


Figure 9. EWR Category A and B Errors by Occurrence

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

JFK Area

The JFK operational area accounted for 22 percent of the 160 errors associated with New York TRACON. However, JFK accounted for 40 percent of the Category A and B errors at the facility. The majority of JFK errors (74 percent) resulted from failure to apply correct wake turbulence separation standards.

Overall errors in the JFK area declined significantly throughout the assessment period. No errors were discovered in the JFK area after March 1, 2005.

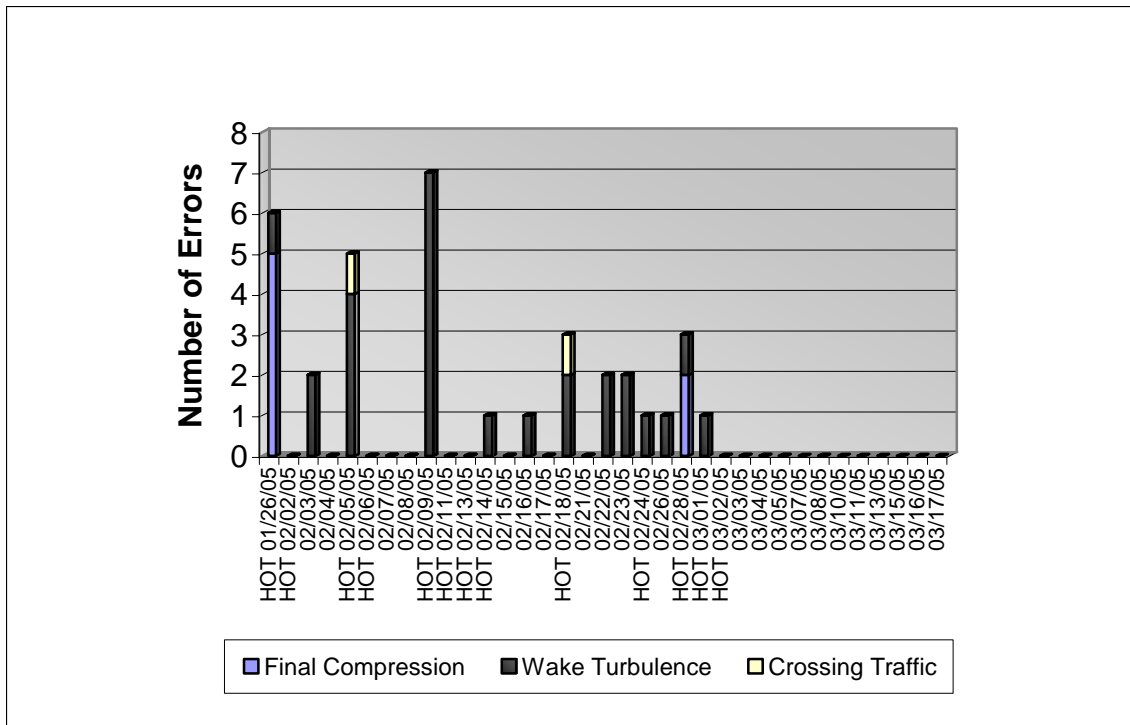


Figure 10. JFK OEs by Occurrence

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

In the JFK area, 94 percent of the Category A and B errors were associated with wake turbulence separation standards. These errors also declined significantly throughout the assessment period as depicted in Figure 11 below. Of all JFK OEs, the closest proximity involved final approach compression with the pair of aircraft at zero feet vertical and 1.18 miles lateral with both airplanes moving in the same direction.

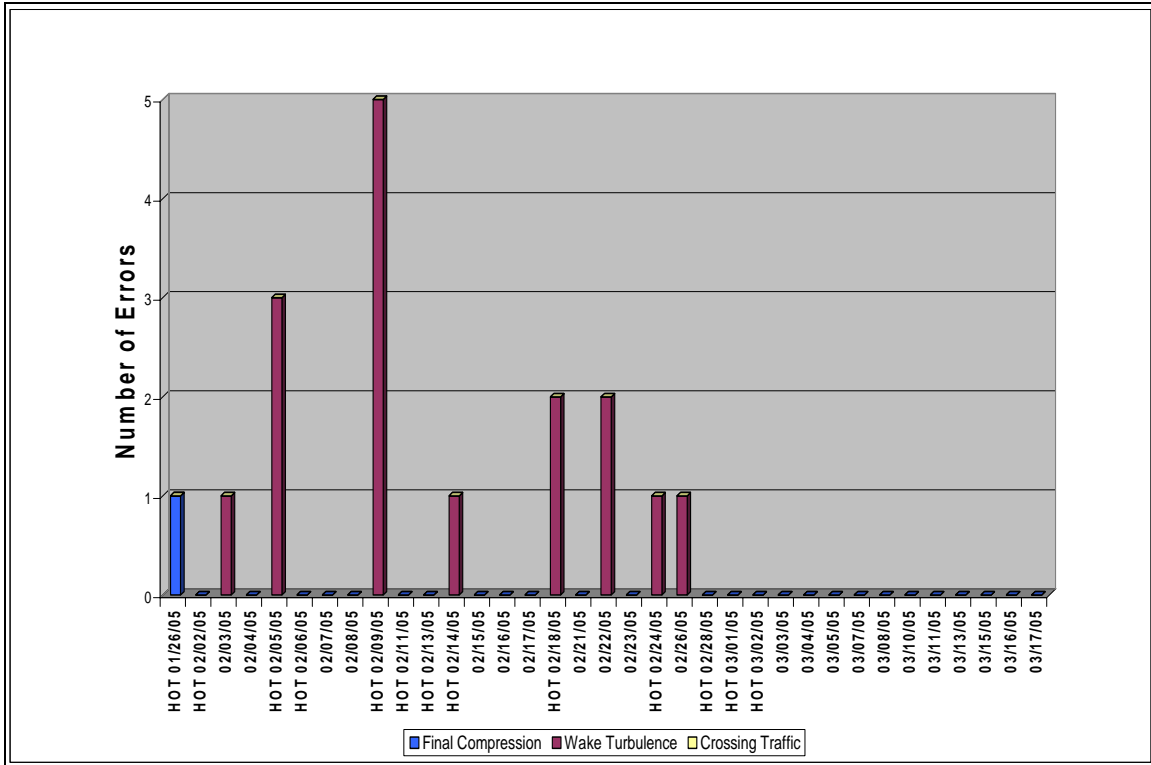


Figure 11. JFK Category A and B Errors by Occurrence

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

In all operational areas, wake turbulence and final compression errors decreased significantly throughout the assessment period. This may be attributed to training, awareness, and performance management initiatives implemented at the facility. However, errors involving crossing traffic remained a problem.

Summary

The team concluded that while errors found during the assessment did not jeopardize safety, management and the controllers need to improve adherence to established separation standards at New York TRACON during the arrival phase of flight. The errors identified at New York TRACON involved many instances of insufficient assigned speed control to ensure aircraft did not compress below the separation standard on final. Also identified were instances of inadequate lateral separation between traffic on downwind/base leg. The most significant issue identified in this assessment was the failure to maintain required wake turbulence separation standards. In fact, all of the most serious (Category A) events resulted from the failure to maintain required wake turbulence standards, no evidence was discovered that such errors actually created a safety concern.

On the recommendation of the the ATO, New York TRACON management immediately initiated refresher training on separation standards for arriving aircraft, particularly heavy jets and B757s. At the time of this report, training of operational personnel was ongoing, as was the assessment team’s presence in the control room to assist New York TRACON OMs and Operational Supervisors (OSs) with ensuring that separation standards were maintained. By end of the analysis period, the pattern had improved dramatically, with significantly fewer wake turbulence and compression errors, as shown in Figures 12 and 13. The team noted that performance had improved by the end of the assessment period in reducing category A and B operational errors as well. Because staffing had not changed, the team concluded that the improved performance was more related to the enhanced supervisor attention, the refresher training conducted, and increased air traffic controller awareness than to staffing issues.

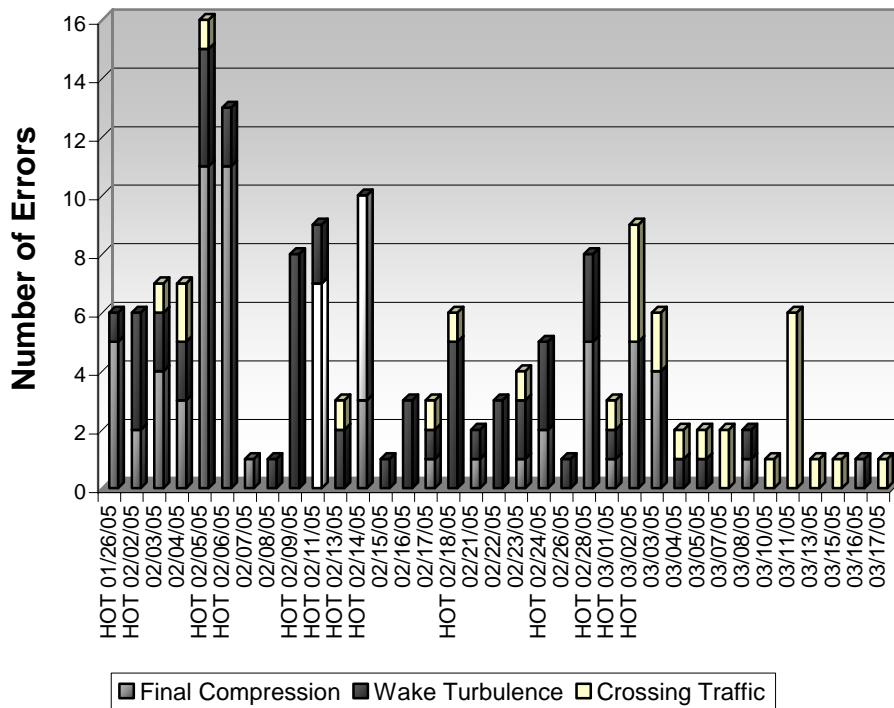


Figure 12. Number of OEs by Category

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

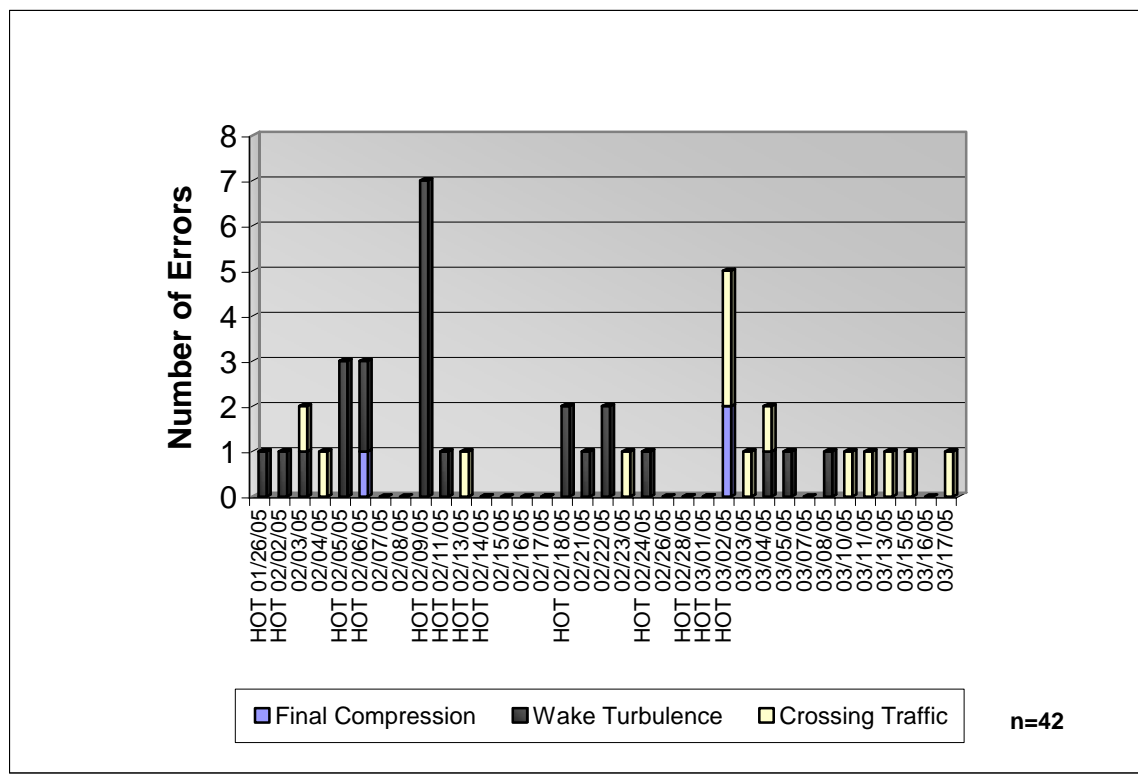


Figure 13. Number of A and B OEs by Category

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

It is also important to note that there were no recorded losses of separation that prompted a known pilot action or a recorded TCAS RA. Given these factors, the assessment team concluded that the integrity of the air traffic system in the New York area was maintained throughout the assessment period.

The assessment team uncovered 147 unreported OEs during the 45-day audit. New York TRACON does not report all of the OEs that occur within the facility’s airspace for several reasons:

- There is no historical incentive for reporting OEs in the current culture.
- Facilities pride themselves on a lack of OEs, and there is no real penalty for not reporting unless intent can be proven.
- There is insufficient emphasis on the importance of reporting errors.
- Controllers do not always know that an error has occurred, considering the pace of operations and the need to constantly shift to the next pair of aircraft.

Failure to report OEs impedes the FAA’s ability to improve facility safety and air traffic controller performance.

Finding #1 Recommendations

1. New York TRACON should conduct mandatory quarterly briefing items to all controllers and supervisors on the application of wake turbulence separation requirements.
2. New York TRACON should develop radar simulation problems for each area of specialization to be used in controller proficiency training.
3. New York TRACON should develop and administer a special refresher training program to emphasize:
 - traffic flows in and out of the New York area
 - airspace containment, and
 - associated procedures to help reduce errors associated with crossing traffic.
4. ATO should explore changes to the Severity Categorization Rating System to address the inherent subjectivity of the OE ratings.
5. ATO should conduct further analysis to more fully understand the causal and contributing factors of OEs within the specific operational areas (i.e., EWR, JFK, LGA, LIB).
6. ATO should institute a follow-up process to all special assessments so that follow-up is conducted within six to twelve months.
7. ATO should develop more realistic separation criteria and policy for the final approach segment (separation standards on final) that allow for natural expansion and contraction.
8. New York TRACON should conduct random radar and voice data reviews to identify unreported OEs.
9. ATO should incorporate radar and voice data reviews into its audit process.
10. ATO should evaluate current New York TRACON radar map displays to determine if improvements to visual aids as related to final approach course spacing can be made.
11. Senior FAA Management should change the ATO culture, processes, and metrics to facilitate and encourage full and open OE reporting.
12. ATO should determine if an Operational Error Detection Program is now practical in the TRACON environment.

Finding #2: New York TRACON was not understaffed.

NATCA Local raised the concern that an increase in operational errors, reported through anonymous Hotline complaints beginning January 31, 2005, evidenced that safety was compromised by a shortage of personnel and reduced overtime.

The assessment team found that NATCA Local allegations were inaccurate. The New York TRACON is not understaffed, and operational errors did not result from staffing levels. Although an MOU between the FAA and NATCA Local authorized up to 270 air traffic controllers, a 2005 ATO staffing study indicated that the TRACON required 170 controllers. The New York TRACON assessment team conducted its assessment assuming a staffing level of 225 controllers, and it is the finding of the team that 225 is currently sufficient to meet operational needs.

An examination of staffing during the period of this assessment (including the specific instances of OEs) showed that available staffing was adequate to support operations. However, the relationship between area staffing and OEs requires more analysis. The controllers' failure to apply required separation minima is not attributable to staffing shortages.

Current Staffing

An MOU between NATCA Local and the FAA in September 2001 authorized New York TRACON up to 250 controllers. The MOU supplied no scientific basis for this number. In June 2002, a separate MOU increased the authorization to 270 controllers due to the implementation of the Chokepoint initiative. In 2005, the ATO issued a Staffing Authorization of 170 controllers. However, the assessment team was not able to inspect the data to validate this number as a requirement. As of February 28, 2005, New York TRACON employed 225 controllers. The TRACON currently has 15 employees, or seven percent of the controller workforce, on detail either on a part-time or full-time basis.

NATCA Local has taken the position that the facility is understaffed, leading to a reliance on overtime. However, facility management maintains that operational needs can be met at current or even reduced staffing levels with minimal overtime, by making changes in scheduling and administrative practices. The assessment team examined staffing trends and staffing associated with recent OEs, and found that the facility is more than adequately staffed.

Staffing Associated with Operational Errors

The Collective Bargaining Agreement (CBA) between NATCA Local and the FAA sets limits for time-on-position without a relief period at two hours, provided operational demands do not require an exception. The assessment team examined the involved controller's time-on-position at the time of each loss of separation that was classified as an OE. The mean for this distribution (time-on-position) was 29 minutes at the time of

the occurrence with a standard deviation of 19.78 minutes. The time-on-position ranged from less than one minute to 81 minutes. This average remained consistent throughout the operational areas (LGA 30 minutes, EWR 27 minutes, JFK 29 minutes). New York TRACON has not conducted an overall time-on-position study due to factors discussed under the Resource Management section of this report (Findings #5-8).

The assessment team also examined the number of controllers assigned to the various service areas (i.e., LGA, JFK, EWR, LIB) who were available to work operational positions at the time of each occurrence. Individuals who were assigned other duties, such as training or CBA Article 17 activities, were not included as available, although supervisors are responsible to recall such individuals if traffic warrants. At the time of these errors, the percent of available controllers who were on break ranged from a low of 22 percent to a high of 65 percent. As shown in Figure 14 below, an average of 46 percent of available staff was on break when errors occurred. An average of 5.14 air traffic controllers were on break at the time of each OE, with a standard deviation of 1.86 controllers.

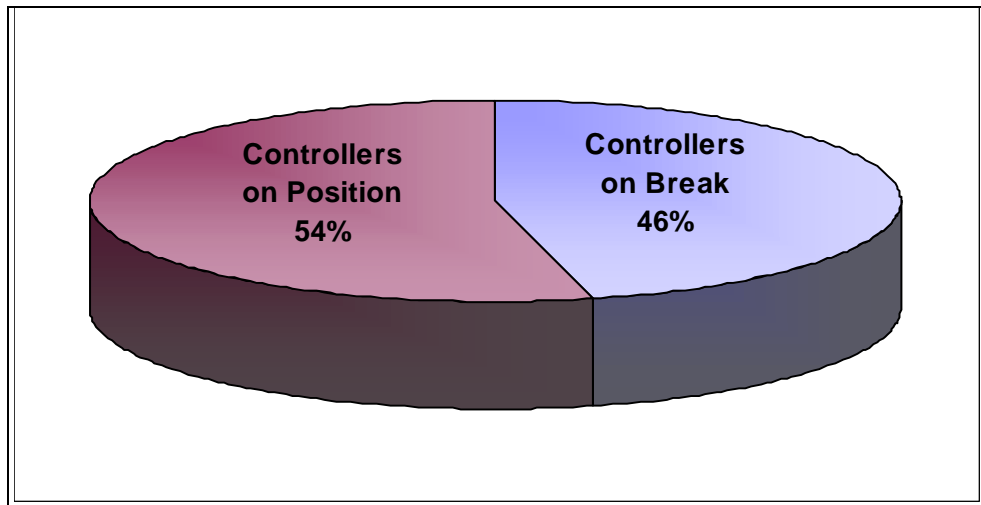


Figure 14. Percentage of Controllers Available to Work During OEs

The assessment revealed 79 OEs in the LGA operational area. In all cases, additional position-qualified staff was available in the building to assist controllers as shown in Figure 15 below.

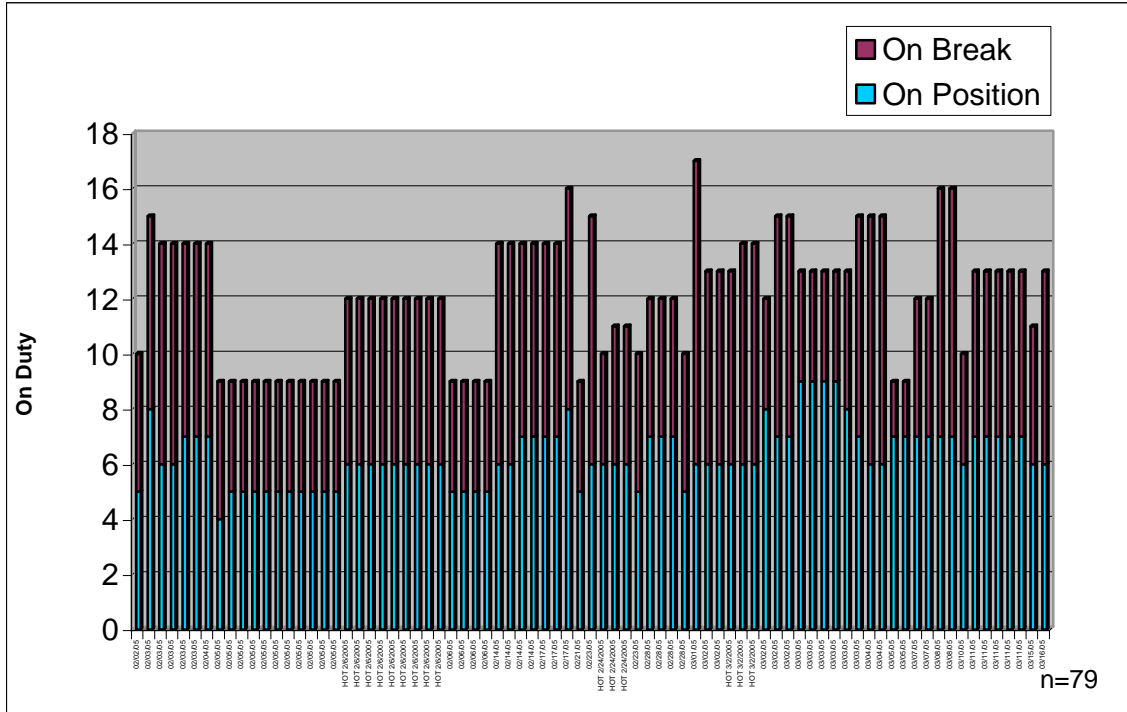


Figure 15. LGA Staffing During Errors

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

This analysis revealed 44 errors in the EWR operational area. At the time of every error recorded, additional sector-qualified staff was available in the building to assist staff on position, as shown in Figure 16 below.

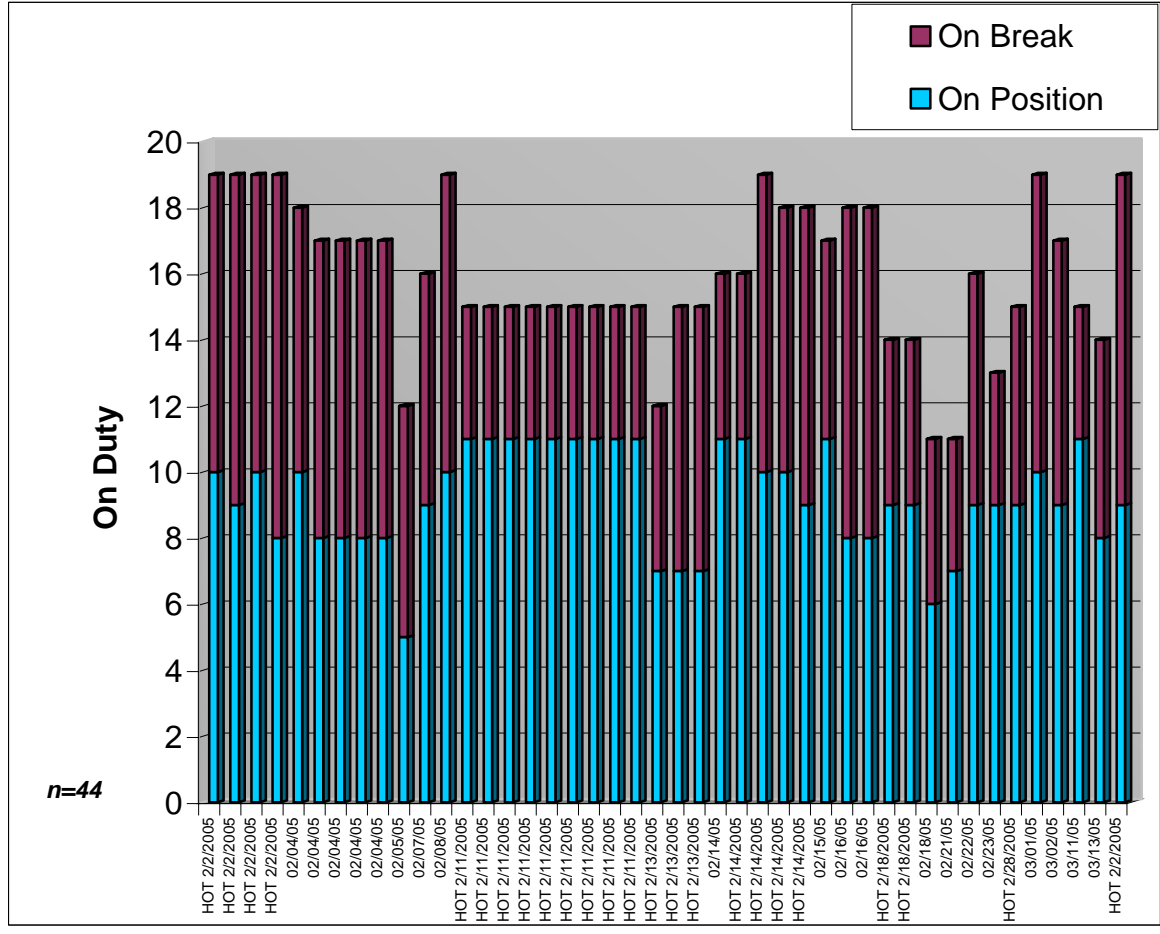
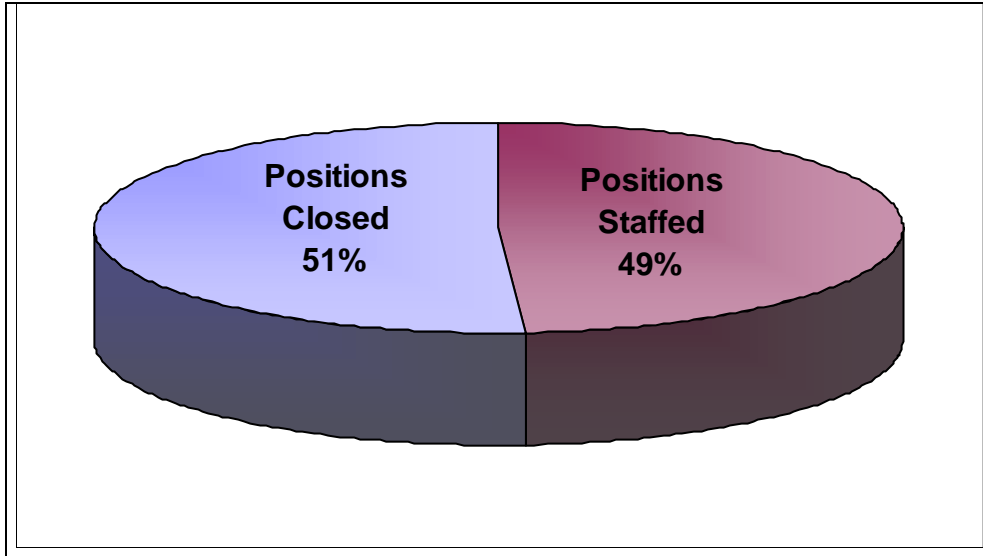


Figure 16. EWR Staffing During Errors

The notation “HOT” associated with the dates on the chart indicates that the date is associated with calls to the Administrator’s Hotline.

The data showed that at the time of the losses of separation, the percentage of available radar positions staffed was as low as 25 percent, while the highest was 64 percent. On average, Figure 18 shows that 49 percent of the possible positions were staffed, with a standard deviation of 1.62 percent of the positions open.



**Figure 18. Number of Positions Open during OEs
(Standard Deviation 1.62)**

Analysis on the traffic volume present during each error indicated that most errors occurred during times of moderate traffic volume (controllers working eight aircraft), as shown in Figure 19 below. This is consistent with the national average of aircraft assigned to a controller (6.9 aircraft) when an error occurs. Traffic volumes at New York TRACON are affected by airline scheduling, and the times of high traffic volume are predictable.

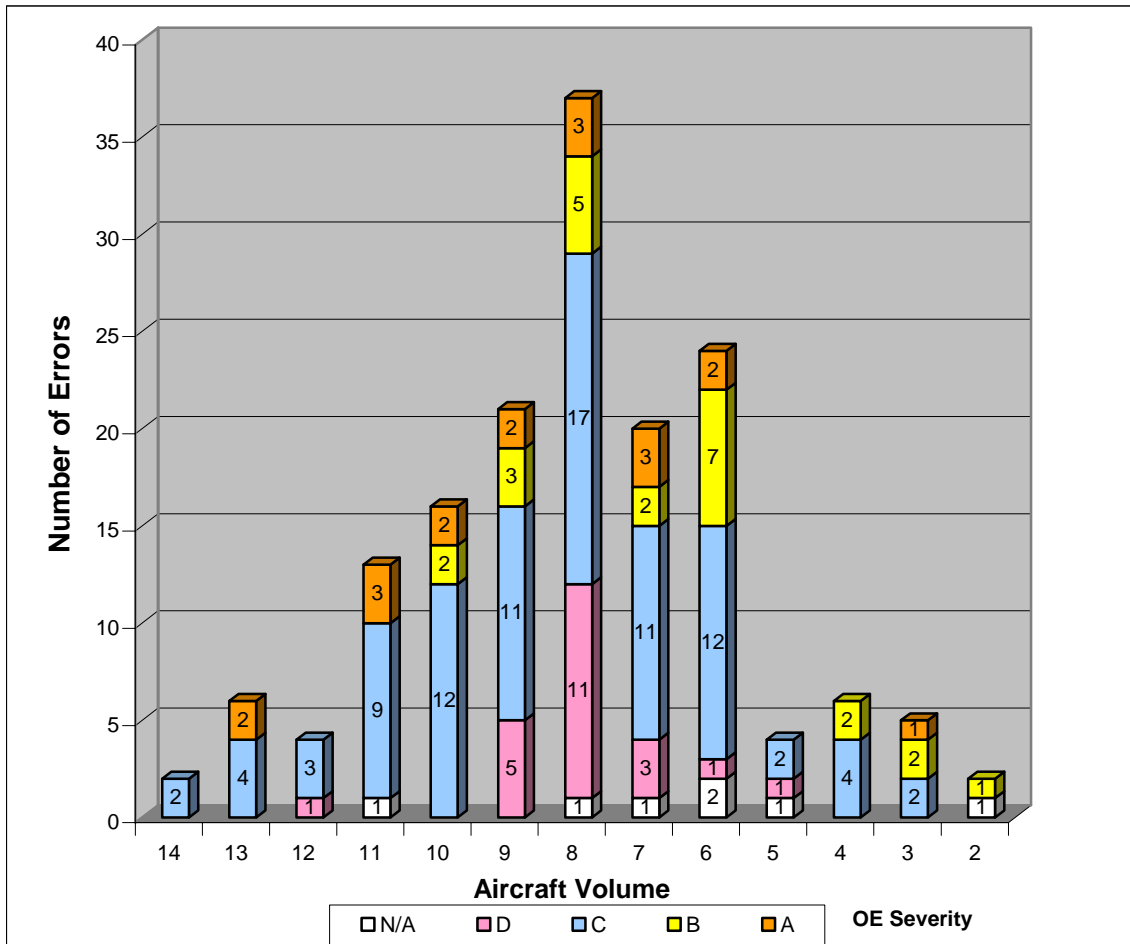


Figure 19. OEs during Levels of Aircraft Volume

When all the data were analyzed, they provided evidence that the number of controllers available to work at any given time was not the limiting factor for the number of controllers actually on position or the number of radar positions staffed. Therefore, the team concluded that the number of controllers available to work at any given time was not directly related to the number of operational errors that occurred.

Figure 20 below graphically illustrates the relationship, or absence of a relationship, of these factors to one another. In the chart, the axis across the bottom indicates controller staffing at the time of one or more errors, ranging from five below to five above the Facility Cooperative Team (FACT) numbers. The magenta bars depict the percentage of available radar positions that are actually staffed, or not combined to other positions. It is important to note that each radar position is designed to enable a controller to work traffic in a particular section of airspace or route segment, and to efficiently flow traffic to and from adjacent positions. Combining multiple positions to one radar position indicates that, in the judgment of the supervisor, the traffic loads in the area were low enough for the sectors to be combined.

The grey bars represent the percentage of controllers who were working on position at the time an error occurred. The remaining controllers can be considered to be on a “relief period” or break from assigned duties. The data points connected by a black line indicate the number of errors that occurred during each staffing configuration.

The number of OEs identified when staffing was below FACT numbers was not significantly different than the numbers of errors identified when staffing was at or above FACT numbers. Eighty-seven errors were identified with staffing at or above FACT numbers, and 73 errors were identified with staffing below FACT numbers.

The far left side of Figure 20 describes a situation in which available controller staffing was five below the FACT numbers. Three of the 160 errors occurred under these circumstances. During the three errors, an average of less than 40 percent of the controllers who were available and assigned to the operation were working, depicted by the shaded bars. Less than 60 percent of the radar positions were staffed. If the supervisor at the time of the errors had judged that controller workload was too high, the ability existed to subdivide the airspace and workload to other radarscopes staffed by controllers who were currently on break.

The far right side of the chart shows that one error occurred when staffing was five controllers over the FACT number. During this error 35 percent of the radar positions were staffed, and 50 percent of the controllers assigned to the shift were working.

Eighty-seven of the 160 errors occurred when staffing was at or above the FACT number. However, regardless of the number of controllers available to the operation, the number of radar positions staffed remained fairly consistent between 40 and 60 percent. At no time did the supervisor responsible to oversee and manage the operation judge that the traffic or complexity warranted staffing all the positions, or even three quarters of them.

The errors that were analyzed supplied the assessment team with 160 “snapshots” of New York TRACON’s resource management practices during a 45-day time period in which safety was allegedly compromised. Taken together, these snapshots reveal a pattern that does not support the argument that assigning more controllers to the operation would equate to more radar positions staffed or fewer OEs.

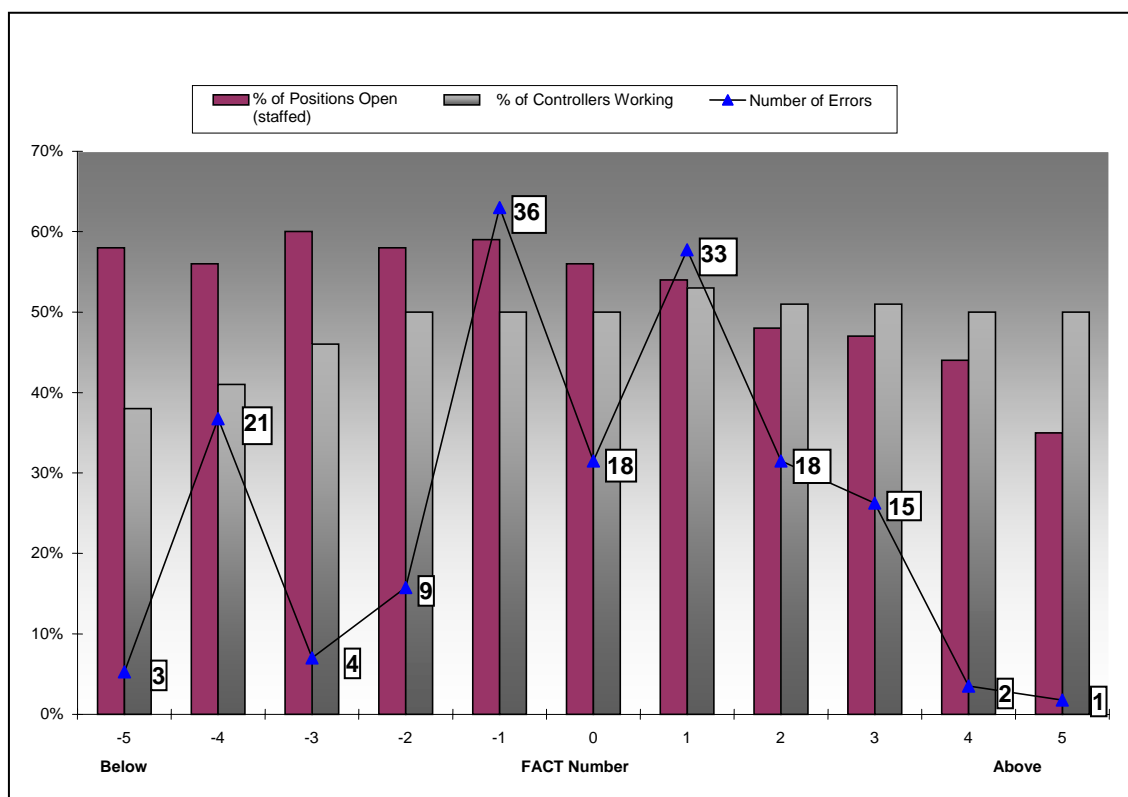


Figure 20. Impact of FACT Numbers on Resource Management

Assignment of Overtime Days Compared to Actual Six-Day Workweeks

New York TRACON controllers work more overtime hours than any other large TRACON even though they have more controllers on-board and handle fewer operations per controller than most other large TRACONs. The circumstances surrounding the assignment of these hours are more fully discussed under the Resource Management section of this report. However, for the purposes of understanding the comparison between overtime and six-day workweeks, a comparison of overtime days worked to frequency of six-day workweeks was done for each area of specialization. The timeframe used was January 16, 2004 to January 17, 2005, because this was the timeframe immediately preceding the complaints of compromised safety.

FAA controllers normally work a five-day workweek followed by two days off. When a controller is asked to work on a day off, this results in a six-day workweek. However, if a controller uses one day of sick or annual leave, the controller would work only five (or fewer) days during a seven-day period.

The data indicated that although controllers were frequently assigned overtime days (some individuals worked 51 days of overtime out of the 52-week year), they worked actual six-day workweeks less frequently. Figure 21 below shows that, on average, 21% of the available controller workweeks (number of controllers x 52 weeks) result in controllers actually working six-day workweeks at New York TRACON. An option to reduce the percentage of six-day workweeks without affecting staffing is contained in Finding #5.

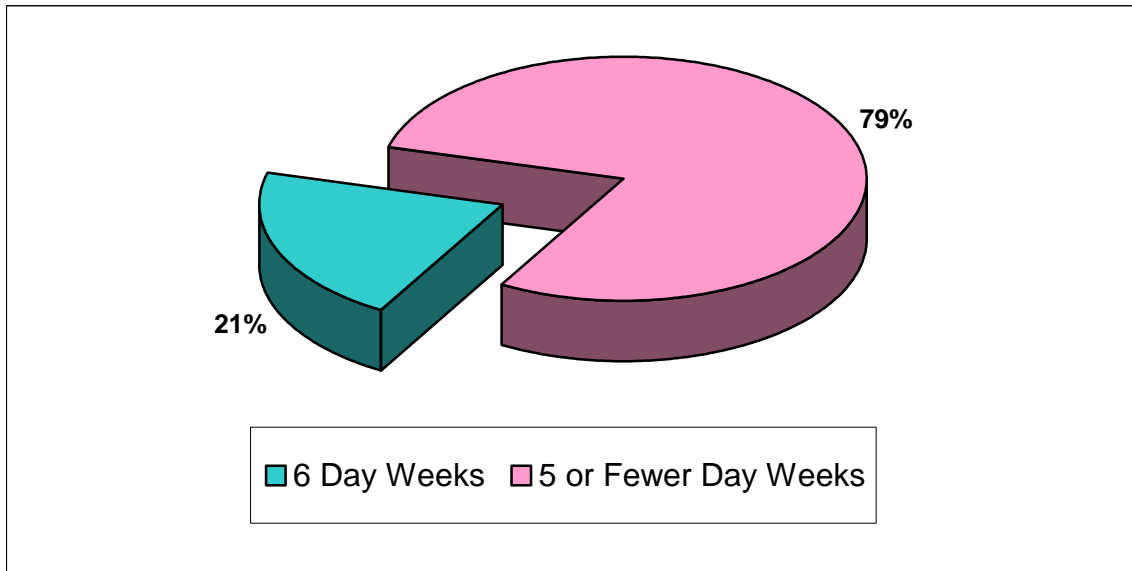


Figure 21. Six-day Workweeks at New York TRACON⁸

Summary

An examination of staffing during the identified OEs and of general staffing trends did not produce evidence to substantiate allegations that staffing levels created a detrimental effect on safety.

Finding #2 Recommendation

13. Management must implement staffing and/or scheduling solutions that reduce the requirement for six-day workweeks and scheduled overtime.
14. After efforts to increase efficiency have been implemented, ATO should complete a staffing study to revalidate staffing requirements at New York TRACON.

⁸ Actual percentage of workweeks at New York TRACON that were six-day workweeks.

Finding #3: The Quality Assurance Program at the New York TRACON has not been effective.

Like other air traffic facilities, the New York TRACON has performance programs to correct performance deficiencies by employees and to provide specific direction for reporting, investigating, and recording air traffic incidents. The team concluded that the programs were not being properly implemented. The team discovered that management's attempts to correct individual performance under these programs were met with resistance from the local union, which in years past had the backing of upper level management at headquarters. Management had little or no presence on the operational floor, and supervisory personnel routinely failed to hold controllers accountable for insubordinate or unprofessional behavior; they also did not provide on-the-spot corrections when controllers made mistakes. The team listened to controllers describe how controllers threaten each other by refusing to give overtime assignments to those who oppose union actions.

Overall performance management conducted at New York TRACON are ineffective because supervisory personnel have been limited in their ability to identify or document noncompliant operational behavior. Further, performance deficiencies identified through external means (e.g., air carriers, pilots) are not always addressed. The controllers' failure to apply required separation standards is attributable to constraints on performance management, rather than staffing shortages.

Quality Assurance Program

One purpose of a Quality Assurance (QA) program is to issue specific direction for the identification and correction of performance deficiencies. It also provides specific direction for the reporting, investigation, and recording of air traffic incidents. QA contributes to continual improvement of the air traffic system. Although QA is frequently misconstrued as the domain of a facility's QA staff, FAA directives clearly assign each employee responsibility and accountability for the quality of air traffic services that are provided to the public.

The New York TRACON QA directive describes the following activities:

- Summaries of Operational Error/Deviation (OE/D) causal factors and trends forwarded to the training department for incorporation into the classroom training
- Semiannual refresher training
- Quarterly OS briefings
- Random reviews of voice recordings
- Annual Technical Training Discussions (TTD)
- Monthly QA Bulletins
- Operational briefings on OE/D causal factors, trends, and corrective actions
- QA group quarterly meetings

The Support Manager for Quality Assurance provided documentation to reflect that all of these items had been accomplished, with the exception of QA group meetings. The assessment team was told that the frequency of meetings of the QA group dwindled because operational individuals (other than the QA staff) failed to attend.

The assessment team noted that the TRACON does not provide feedback to controllers concerning trends or errors. Tools such as the Radar Audio Playback Terminal Operation Recording (RAPTOR) capability were not employed to conduct training and discussion of operational trends or recent errors with individual controllers or groups of controllers.

Although some information was shared through briefings and proficiency training, the irregular nature of the information hindered improvement in the day-to-day operation because no effective follow-up was conducted. The TTDs, which are designed to provide a documented history of each controller's performance, contained little or no information.

Quality Performance

The New York TRACON has performance programs designed to correct performance deficiencies by employees and to provide specific direction for reporting, investigating, and recording air traffic incidents. The team assessed these programs and concluded that they were not being properly implemented. Historically, New York TRACON has not had a culture of strong quality management. Individuals commented to the assessment team that the OM's and OS's had never been charged or given the authority to fulfill their watch supervision duties. The assessors' observations substantiated an absence of management oversight in the TRACON. The OM-in-Charge (OMIC) was located on a raised platform from which it was not possible to view a large portion of the control room. OS's did not provide on-the-spot corrections. The team documented evidence of local union representatives engaged in intimidating behavior and the use of profanity was rampant. Inattention to duty was not corrected. The assessment team obtained recordings of New York TRACON controllers threatening each other by refusing to give overtime assignments to those who oppose union actions and using profanity on radar handoff lines. The team discovered that management's attempts to correct individual performance were met with resistance from the union and that the union's resistance was in many cases supported by upper level management at headquarters.

As the assessment progressed, the increasing attention on controller performance with regard to separation minima began to effect change. The continued presence of assessors in the radar room for the purpose of supporting the local facility management was critical to ensuring this trend did not reverse because of pushback from noncompliant individuals.

Quality Assurance Reviews

The predecessor office to the ATO established the Quality Assurance Reviews (QAR) process to capture system performance during events that might not normally result in an investigation (e.g., emergencies, pilot complaints, and incidents other than OE/Ds). At New York TRACON, QARs were conducted and documented by the QA office whenever telephone calls from external sources identified a potential performance issue. However, a review of the facility's FAA Form 7230-4, Operations Log, revealed that QARs were seldom conducted for events such as emergencies, and TCAS events. When QAR entries were documented, the actual investigation was minimal and no documentation substantiating closure was available. The Support Manager for Quality Assurance stated that the supporting QAR documentation, which was required to be retained, could not be located. As a result, QARs were not provided to OSs to ensure that the information was documented on the employee's semiannual TTDs.

Technical Training Discussions

The team reviewed TTDs for 98 individuals at New York TRACON:

- 22 from LGA area
- 17 from EWR area
- 21 from JFK area
- 24 from LIB area
- 14 from ISP area

There were no technical deficiencies identified on any of the TTD forms, even when attached tape talk reviews included OEs. Two TTDs contained attached OE information and an accompanying training plan, yet the training was not documented as required. Only one TTD contained documentation of a controller's performance identified during a QAR. The TTDs suggested that OSs were deficient in the area of critiquing the performance of the controllers they supervised.

Summary

Reviews of the quality management programs indicated that no action had been taken by supervisory personnel to discuss deficiencies with employees that could have had an impact on possibly preventing many of the errors identified through this assessment. Controllers were not held accountable for their actions in the operating quarters and supervisory personnel do not take advantage of the QAR and TTD programs to detect performance trends that could impact safety. The team conducted a separate but concurrent assessment of the environment and operating culture at the New York TRACON. Their observations and conclusions are discussed in greater depth in finding #8, on page 52.

Finding #3 Recommendations

15. ATO senior management should strengthen QA effectiveness by:
 - a. Changing the reporting structure at Air Traffic facilities so that QA departments report directly to the Service Area QA Office.
 - b. Revamping the national QA personnel training program to focus more on operations than on administration.
16. New York TRACON should enhance performance management at all levels, including on-the-spot corrections when deficiencies are observed.
17. New York TRACON should make necessary changes to OMIC and OS positions to improve safety oversight of the control room floor. Management should consider a closed-circuit system to monitor areas not visible from the OMIC platform.
18. New York TRACON should enhance operational safety oversight by integrating administrative Operations Managers into the operations environment so that they can directly interface with supervisors. OMs should be directed to work in the control room at least 50 percent of scheduled hours.
19. Facility Management should enhance training to supervisory personnel on the necessity for identifying exceptional performance and deficiencies in technical training discussions.
20. Facility Management should provide enhanced training to all personnel on the importance of identifying air traffic incidents that require QAR.
21. The QA Office should use RAPTOR and other tools to review operational trends and recent errors with controllers.
22. The QA office should develop a tracking program to ensure QARs are investigated properly and the results are discussed with employees during TTDs.

Resource Management

Finding #4: New York TRACON has the highest overtime cost per operation of any large TRACON.

Despite the fact that the New York TRACON has more controllers and handles fewer operations per controller than almost all other large TRACONs, the New York TRACON expends more in overtime than all other large TRACONs and has the highest overtime cost per operation. Throughout this report, large TRACON is used to refer to the Level-12 facilities handling similar traffic types and volume. Overtime includes only controller personnel (financial codes 0053 & 0061). Total overtime costs and overtime costs per operation at New York TRACON are more than double any other large TRACON.⁹

Overtime Cost per Operation at New York TRACON

New York TRACON has significantly higher overtime costs per operation than comparable TRACONs for both Fiscal Year (FY) 04 (Figure 22) and FY 05 (Figure 23).

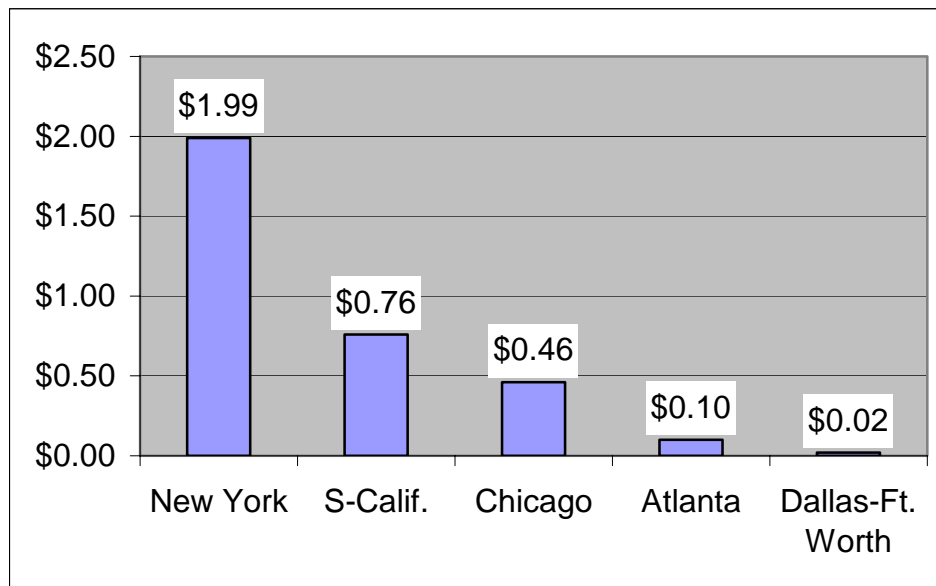


Figure 22. Overtime Costs per Operation at Large TRACONs (FY 04)

⁹ The assessment team did not include Northern California and Potomac TRACONs in the overtime comparison for FY04 because of the short operational history at both facilities.

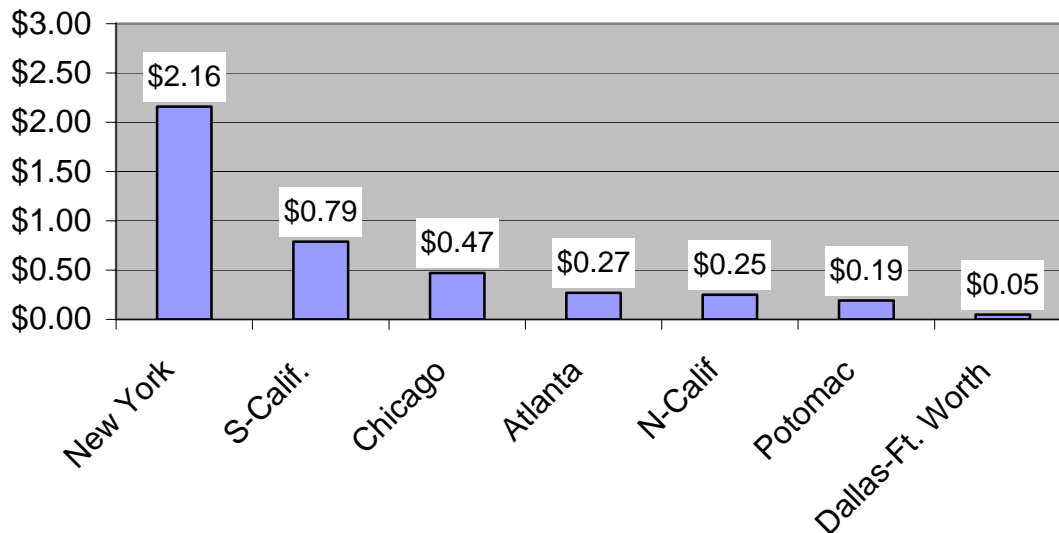


Figure 23. Overtime Cost per Operation at Large TRACONs (FY 05)

As shown in Figure 24 below, although New York TRACON has more Certified Professional Controllers (CPCs) on board and fewer operations per controller than most other large TRACONs, the facility expends significantly more dollars in total overtime costs.

FY04	Total Operations (IFR)	Total Controllers (CPC) On Board	Ops per Controller (CPC)	Total Overtime
New York	2,066,708	210	9,841	\$4,122,971
Southern California	2,124,033	235	9,038	\$1,628,122
Chicago	1,502,382	74	20,302	\$696,672
Atlanta	1,386,610	69	20,095	\$148,545
Dallas Ft. Worth	1,305,622	90	14,506	\$34,829

Figure 24. CPCs on Board, Operations per Controller, and Operational Overtime at Large TRACONs (FY 04)

Summary

The team conducted a detailed assessment of the use of overtime at the New York TRACON. The New York TRACON has the highest overtime costs of any TRACON in the country. New York TRACON's bill for overtime -- \$4.12 million -- more than twice the next most costly facility.

Finding #5: Current scheduling practices require unnecessary overtime to meet operational needs.

Currently, controller shift schedules at New York TRACON are not efficient in terms of resource utilization because the facility does not schedule days off in a manner that allows the facility to meet operational requirements without expending overtime. The current scheduling practices do not equitably distribute days off, and do not schedule sufficient personnel for peak traffic periods. These practices are due to past “partnership” agreements and inconsistent labor/management philosophies at the regional and national levels.

Background

Scheduling of personnel at New York TRACON, like most air traffic control facilities, is done based on a “watch schedule” concept. A watch schedule or daily schedule is a roster of personnel assigned to cover operational requirements on a shift-by-shift basis. The watch schedule is covered in an agreement with NATCA Local. Article 32, section 1 of the CBA states:

The basic watch schedule is defined as the days of the week, hours of the day, rotation of shifts and change in regular days off. The basic watch schedule must satisfy coverage requirements. Once posted, the basic watch schedule may not be renegotiated except for substantial operational reasons, or unless specifically requested by the Union. Permanent/rotating shifts and/or permanent/rotating days off are options which may be considered.

The assessment team defined an efficient scheduling process as one that meets coverage requirements including provisions that:

1. Meet operational needs for shift and traffic coverage throughout the week,
2. Ensure staffing to allow for scheduled annual leave,
3. Minimize requirements for six-day workweeks and overtime that may increase fatigue,
4. Distribute days off in an equitable manner, without a requirement to have all facility personnel on duty on any specific day each week and,
5. Provide for verbal/team briefings on a routine basis.

New York TRACON Operational Area Staffing Requirements

Requirements for staffing individual operational areas are determined on a per-shift basis, and schedules are posted to meet these requirements. Current area staffing requirements at New York TRACON were addressed through the Facility Cooperative Team (FACT) agreement process in the early 1990s.

FACT Process

During the early 1990s, the FAA implemented several “partnership” initiatives. One initiative at New York Center called Success Through Partnership established a partnership council consisting of designated facility and union personnel to represent all operational areas of the facility. The goal was to increase input from the workforce on operational and procedural issues. This initiative was adopted for the entire Air Traffic Services office, and it became known as Quality Through Partnership (QTP).

QTP consisted of FACT and Area Cooperative Teams (ACT). The FACT was a full-facility representative council, with equal numbers of management and NATCA Local representatives, while the ACT was a smaller team designed to address only area-specific issues. Each team had a set of gatekeepers composed of a union and a management representative who determined which issues the team would accept and address.

In New York TRACON, previous facility management chose to have the FACT address issues that were traditionally regarded as management rights. The result was a series of agreements that compromised management’s ability to set work schedules, determine staffing, and allocated overtime and the use of credit hours. In addition to operational and procedural issues, the FACT was delegated authority to address budget issues.

Minutes of these FACT meetings were used to document decisions and the minutes became ‘de-facto’ agreements. One of the records the facility currently relies upon to determine the required staffing numbers per shift each day is referenced in the September 28, 1995 FACT Gatekeeper Meeting minutes, which in part, state:

2. Facility staffing numbers – overtime backup agreed to using 8/94 staffing numbers. FACT decision September 1992, states FPL’s and PQ’s count for scheduled staffing. Facility gatekeepers will distribute FY96 overtime budget to area in lieu of agency budget using past formula. Area gatekeepers have latitude to operate within the framework of the overtime budget....

The record of the controlling August 1994 staffing numbers is missing from the records. However, the number of controllers that each area staffs is based upon those numbers.

Current Area Staffing Requirements

The current staffing numbers attributed to the FACT minutes for each area are shown in Figure 25 below.

	EWR	LIB	JFK	LGA	ISP
Day Shift	16	12	8	12	9
Evening Shift	16	14	12	13	9
Mid Shift	3	2	2	2	2
Total	35	28	22	27	20

Figure 25. New York TRACON Area Staffing Requirements

For many years, New York TRACON has scheduled overtime when staffing numbers drop below FACT minute figures. Overtime is used to cover prime time annual leave, NATCA Local official time, controllers on work details away from the facility, sick leave, and a variety of other reasons.

Current Scheduling Practices

The following information is based on interviews with facility personnel.

Three-team schedule

New York TRACON currently employs a three-team concept¹⁰ in most areas, which requires large unnecessary overtime expenditures. Under this schedule, most employees have Wednesday/Thursday, Friday/Saturday, or Sunday/Monday as regular days off on the posted watch schedule. However, a small number of employees have Saturday/Sunday off. The facility uses Tuesdays as a training day each week. Due to its lack of flexibility, the three-team schedule does not allow the facility to maximize personnel for peak traffic times.

The current schedule that is in place at New York TRACON does not satisfy coverage requirements without the use of overtime on a scheduled basis. As shown in Figure 26 below, in FY 04 New York TRACON spent \$4,122,971.00 in overtime costs. FY 05 overtime costs are \$2,084,615 through March 19, 2005 and at the current rate of overtime usage, the figure may double by the end of the fiscal year (to more than \$4.5 million). It should be noted that the facility projects the overtime usage will be lower in the last half of the fiscal year due to a revised credit hour policy. (Please see Finding #7 for more information.)

¹⁰ The TRACON does not use a true “three team concept,” since four pairs of days off exist in the schedule, rather than three pairs.

Area	FY04 Overtime	FY05 Overtime as of March 19, 2005
Newark	\$1,551,174	\$741,083
Kennedy	\$820,665	\$346,790
LaGuardia	\$731,741	\$532,975
Islip	\$500,011	\$221,128
Liberty	\$430,230	\$177,686
Traffic Mgmt. Unit	\$89,150	\$64,953
Total	\$4,122,971	\$2,084,615

Figure 26. Overtime Usage With Current Schedule

Inefficient scheduling and staffing, staffing shortages due to high usage rates of the Office of Workers' Compensation Programs (OWCP), numerous assignments of personnel out of the facility, have created a significant operational need to restructure area staffing.

Seven-team Scheduling Alternative

Currently, all other large TRACONs use a seven-team schedule, which would virtually eliminate overtime at the New York TRACON using the same number of controllers. The New York TRACON would save \$3.6 million per year by implementing the seven-team schedule.

Comparisons of a three-team and a seven-team scheduling concept for the five areas in New York TRACON were conducted. For comparison purposes, the FACT minutes staffing figures are assumed as reference points to illustrate the difference in coverage. Current staffing of 225 controllers is also assumed.

For example, under the current three-team schedule in the EWR area, there are 16 more controllers available to work on Tuesday than are needed under the FACT staffing numbers (51 available versus 35 required). In addition, there is one less controller available to work on Sunday than is required under the FACT staffing numbers (30 available versus 31 required). This results in a surplus of 16 available controllers on Tuesday and requires one scheduled overtime to cover Sunday, which results in additional six-day workweeks.

A seven-team schedule allows for a more even distribution of controllers to work the required shifts and should eliminate the need for scheduled overtime. For example, on Tuesday, there would be 35 controllers available to work the 35 shifts required under the FACT staffing numbers. In addition, on Sunday, there would be 37 controllers available to work the 31 shifts, thus eliminating the one scheduled overtime to cover Sunday and

providing six controllers to cover sick leave or annual leave. This would also reduce or eliminate the need for six-day workweeks.

An example of how the seven-team schedule would work is provided by proposed schedules for a two-week period (June 12- 25, 2005). The first schedule is the NATCA-proposed schedule which has been submitted to management for approval. This schedule was based on a three-team concept and included 171 shifts of overtime for the two-week period at a total cost of \$139,536. An alternate schedule was prepared by management using a seven-team concept. This schedule allowed for some extra shift coverage to compensate for changing days off and provided one shift of overtime to accommodate a “lab” that had already been scheduled. That schedule required no further use of overtime.

Figure 27 below depicts the cost comparison for the two schedules.

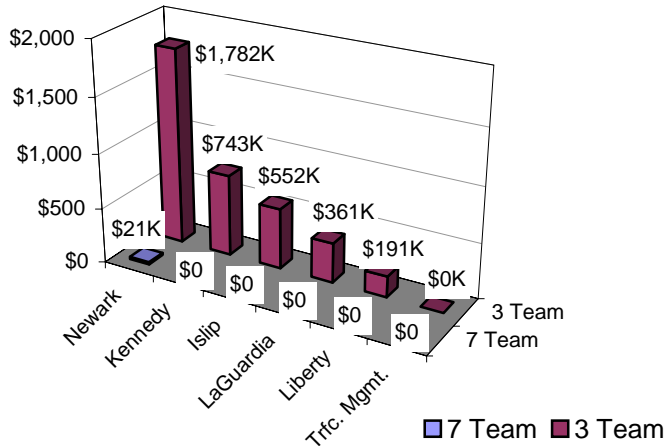


Figure 27. Projected Annual Overtime Expenditures at New York TRACON Three-Team Schedule versus Management’s Seven-Team Schedule¹¹

Summary

After analysis of FACT staffing numbers, it is the judgment of the assessment team that implementation of the seven-team schedule should enable the facility to reduce overtime based on more controllers being available to cover for annual leave and other absences. Elimination of the present FACT minutes scheduling requirements, implementation of “staffing-to-traffic” (now in place at most other facilities), and a seven-team schedule which is used at all other large TRACONs -- should enable the facility to eliminate nearly all overtime and six-day workweeks using existing personnel – saving the FAA \$3.6 million per year.

¹¹ Projected annual overtime expenditures at New York TRACON are based on actual schedules for a single pay-period; annual totals were extrapolated for 26 pay-periods.

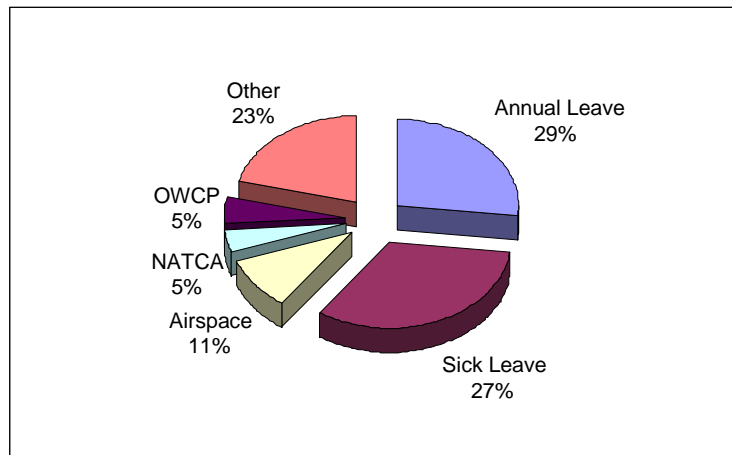
Finding #5 Recommendations

23. The ATO's Eastern Service Area Director-Terminal should rescind the FACT agreements at New York TRACON.
24. New York TRACON management should eliminate scheduling as part of Article 17 duties.
25. New York TRACON facility management should exercise its rights to determine staffing.
26. New York TRACON facility management should implement a team concept for controller shift scheduling that will resolve scheduling issues, reduce overtime costs, and address a significant operational need to improve performance management in the mitigation of OEs.

Finding #6: Schedule manipulation, low time-on-position, inappropriate use of sick leave, and high rates of OWCP at New York TRACON contribute to its high cost per Air Traffic operation.

Abuse of leave entitlements and schedule manipulation at the New York TRACON have dramatically increased operational costs. Specifically, the team uncovered evidence of schedule manipulation, low time-on-position, as well as inappropriate use of sick leave and unusually high OWCP claims.

Figure 28 below breaks down the FY 04 overtime costs by the percentage attributable to various categories. Sick leave and annual leave categories, which combined represent 56 percent or \$2,332,021 of the total, are directly related to the current leave approval policy and a work force that has historically used almost 100 percent of earned sick leave on an annual basis.



	Total OT FY04	Percent of Total
Annual Leave	\$1,203,990	29%
Sick Leave ¹²	\$1,128,031	27%
Airspace	\$446,723	11%
NATCA	\$188,028	5%
OWCP	\$217,510	5%
Other ¹³	\$938,689	23%
	\$4,122,971	100%

Figure 28. Overtime by Category

Scheduling

Currently, NATCA Local is in charge of making the watch schedule, per Article 17 of the CBA, and posting it every 28 days. The schedule is required to allow for employee

¹² Sick Leave totals include some supervisory overtime.

¹³ Includes STARS, Hold Over, New YorkICC-consolidated airspace, Medical/FMLA, jury duty, etc.

leave. In order to accomplish this, the scheduler can schedule up to four leave slots for each area each day. Although this is not necessarily done for each day, the team was advised that occasionally people without leave requests are scheduled. In these cases, controllers show up without prior coordination, canceling their leave. This practice often requires scheduled overtime. The assessment team was also informed that if less than four people request annual leave, the scheduler will nonetheless show an additional controller on annual leave and then schedule the overtime if necessary. When the controller ostensibly on annual leave arrives for work, the person on overtime cannot be sent home, and both controllers work. This practice increases overtime hours unnecessarily, and results in an operation that is overstaffed. Once the schedules have been posted, the scheduler does receive additional requests for prime time leave. At times, these requests are granted and being backed up with overtime.

The team uncovered another example of how schedule manipulation works. One controller calls in sick. Another controller agrees to come in on his/her day off to take the place of the “sick” controller. The replacement controller gets overtime, which is paid out at time and half. The replacement controller calls in “sick” during a subsequent pay period so that another controller is assured of overtime. Further verification and quantification of questionable scheduling practices was beyond the scope of this assessment but warrants further consideration for investigative review.

Time-on-Position

The assessment team examined time-on-position for all areas at New York TRACON for one week and determined that the average controller spent 3 hours and 39 minutes (3:39) on position during an eight-hour shift. This Time-on-Position (TOP) is less than that at other large TRACONs as shown in Figure 29 below.

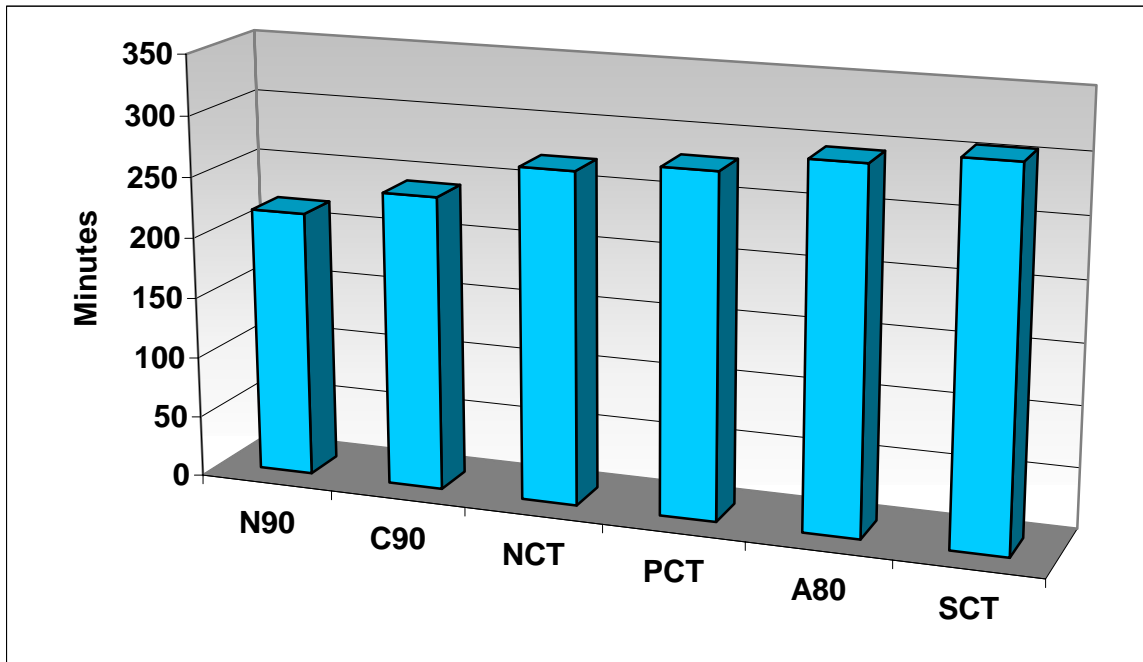


Figure 29. Time-on-Position FY 05 YTD for Large TRACONS¹⁴

When controllers work air traffic positions at the facility, they keep track of their time-on-position using a position log. An automated Sign In Sign Out (SISO) capability is in use at the TRACONS listed in Figure 29 except New York TRACON. At New York TRACON, all SISO information is manually entered onto Form 7230-10, Position Log, because they have chosen not to use SISO. The assessment team was informed that SISO was not part of the ARTS IIE package; the accuracy of SISO is questionable; it is the assessment team's understanding that the bargaining unit chose not to use it.

Although the FAA's automated SISO capability is still technically subject to some of the same manipulations as the current manual process, it has some distinct advantages. First, the FAA's automated SISO capability would enable supervisory personnel to monitor the sign in sign out process on the computer at the supervisory workstation, permitting easier operational oversight. Second, the capability would produce reports in an automated fashion, which would allow more complete data management and oversight by senior facility management. The assessment team compiled time-on-position data for only one week because of the time required for the data mining from manual sign in sheets.

¹⁴ New York TRACON data for FY 05 was not available because of the lack of automated data collection capabilities. To complete this chart, the assessment team calculated time-on-position for one week (January 23-29, 2005) for all New York TRACON controllers. Only one week was completed due to the labor-intensive nature of the process.

Evidence was presented to the assessment team that controllers were signing on positions when they were not actually working traffic. In at least one case during the assessment, disciplinary action was taken as a result of this practice. On May 9, 2005, a local NATCA representative management fired a local NATCA representative for falsifying time-on-position records, insubordination, and intimidation. Further verification and quantification of this practice was beyond the scope of this assessment but warrants further consideration for investigative review.

Sick Leave

The team found evidence that controllers routinely work overtime on their scheduled days off and then use sick leave to offset the overtime day. The result is a five-day workweek with one of the days paid at time and a half. There are also many instances of employees using their sick leave because they have exhausted annual leave or they cannot get approval to use annual leave. Facility management conducted an assessment in FY 2004 and found numerous instances of these practices. Traditionally, New York TRACON uses more sick leave than they earn, as shown in Figure 30. Close monitoring of controller and supervisor sick leave practices is warranted.

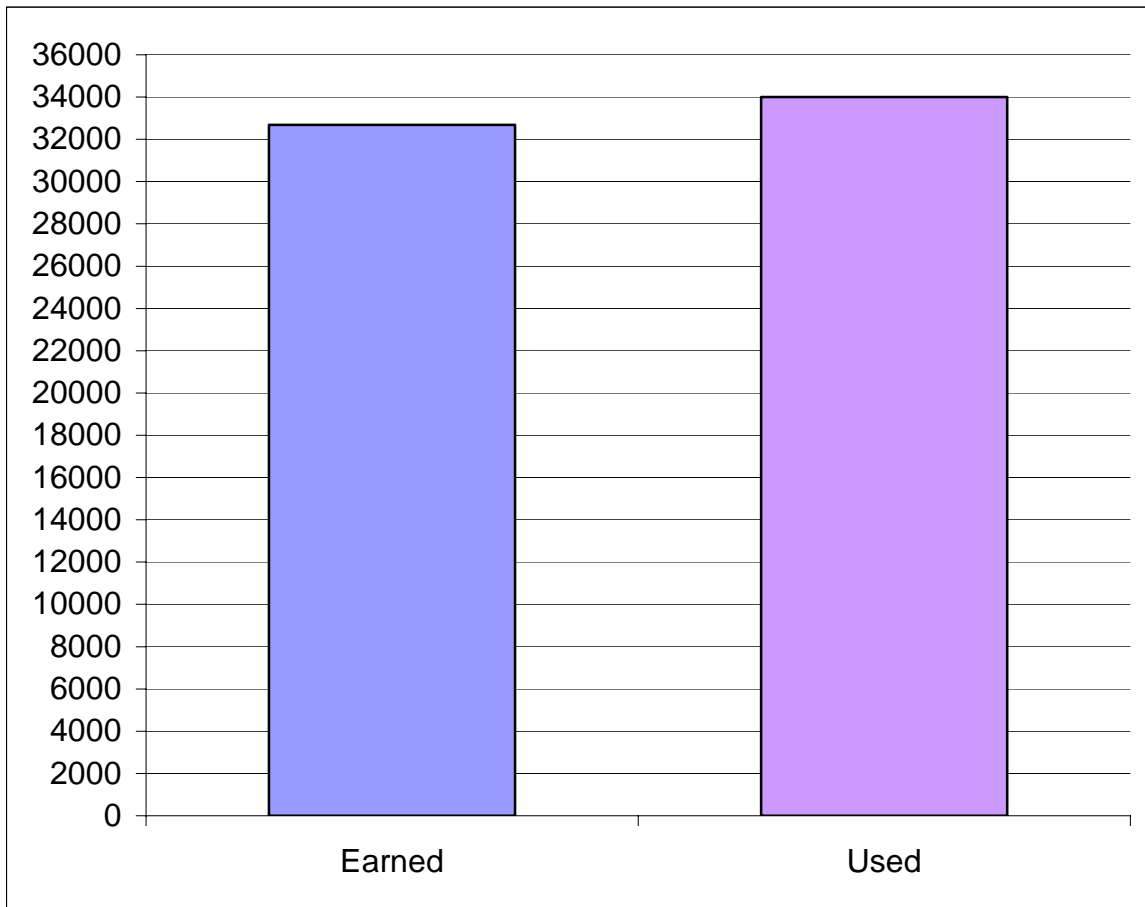


Figure 30. Sick Leave Earned and Used (in hours)

Occupational Workman’s Compensation Program

The number of OWCP hours lost at New York TRACON is excessive compared to other large TRACONs, as shown in Figure 31 below. Employee OWCP claims at New York TRACON in FY 05 have resulted in 3,030 hours of lost work time through pay period 7, which is equivalent to the loss of two full-time employees per day.

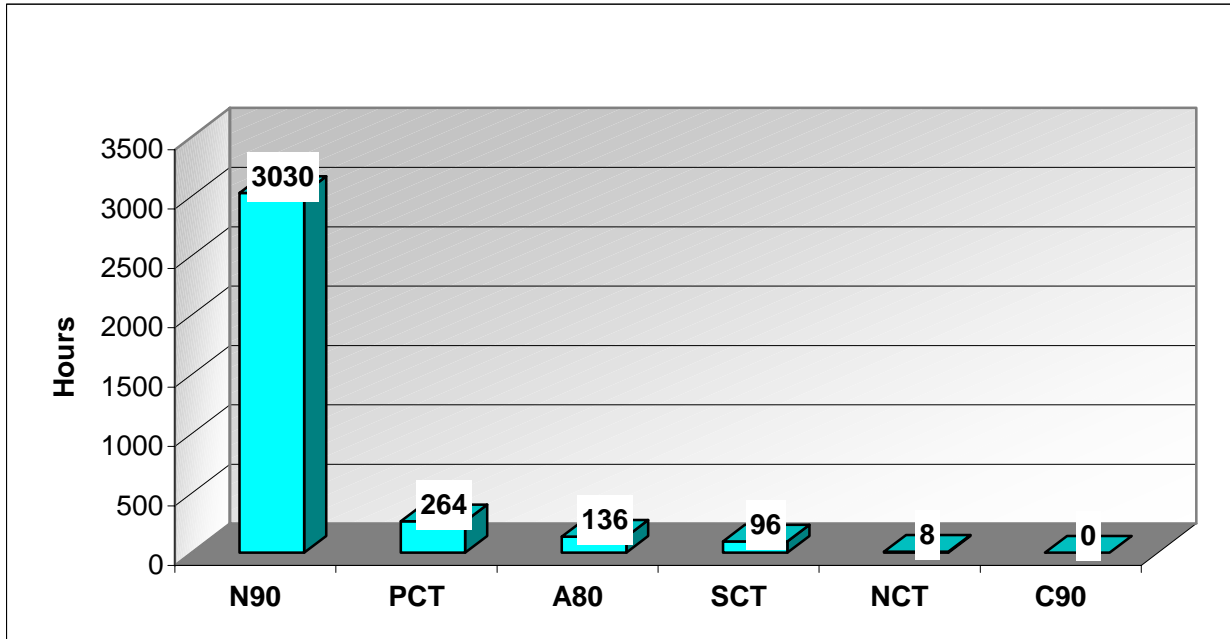


Figure 31. OWCP Hours Used at Large TRACONs

The use of OWCP at New York TRACON stands in stark contrast with other large TRACONs. Further verification and quantification of this practice was beyond the scope of this assessment but warrants further consideration for investigative review.

Management Progress

Despite significant resistance and legacy practices to the contrary, current facility management has implemented significant initiatives to address inefficient practices. Below are two examples of such initiatives.

Credit Hour Policy

New York TRACON facility management conducted an investigation into questionable practices and developed a strategic plan to address some of the problems. However, only one part, concerning more stringent approval of credit hours for employees, was implemented, in July 2004. The Memorandum of Understanding (MOU) that allowed controllers to earn credit hours on an unlimited basis without management approval was

rescinded. Management approval is now required for credit hours. This program is still in place and has reduced the number of credit hours earned in FY 2005 by 95 percent from FY 2004 as shown in Figure 32 below.

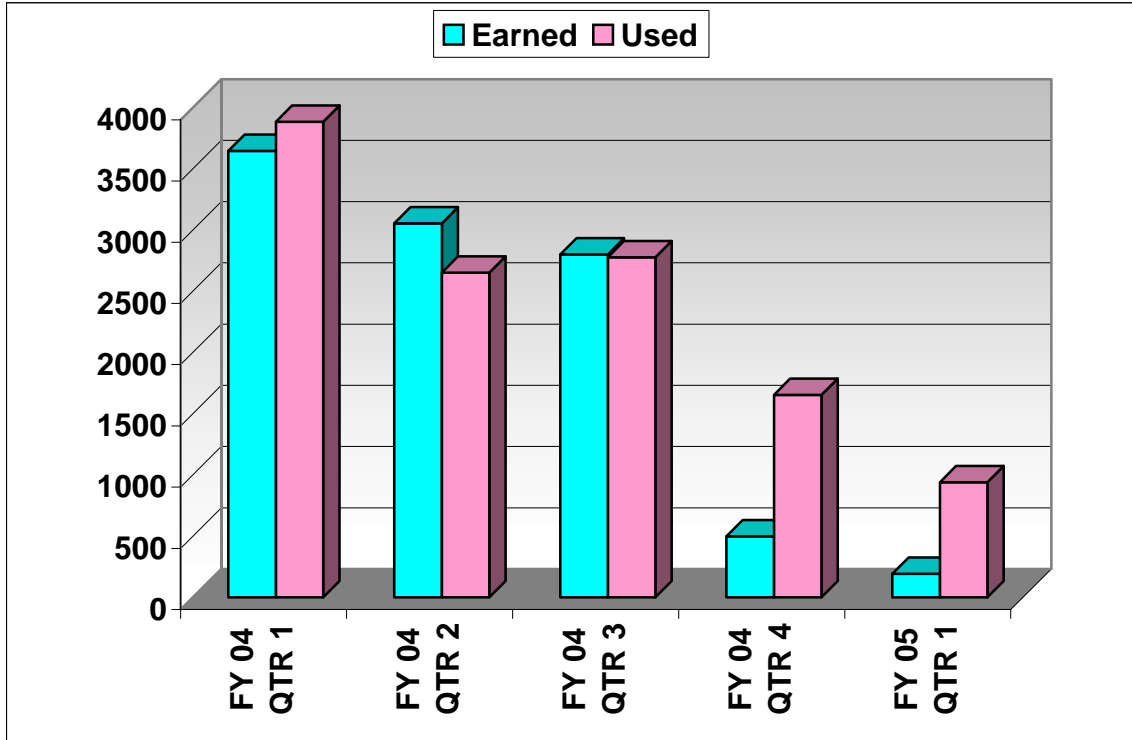


Figure 32. Credit Hours at New York TRACON in FY 04 and FY 05

Recurring credit hours drive up facility costs because they are used much like annual leave and very often require overtime to backfill absences resulting from credit hours. As a result of this policy change, the facility expects to realize a reduction in overtime costs in FY 06 when credit hour balances will be depleted. On July 10, 2004, the facility credit hour balance was more than 5,461 hours. On April 2, 2005, the facility credit hour balance was 3,474 hours.

This new policy was an essential step in management regaining control of the schedule and the ability to assign controllers when needed. The previous policy permitted unlimited accrual of credit hours, which could be converted to leave. The new policy will manage the amount of leave available to controllers, allowing management to control overtime costs.

Overtime Approvals

In 2004, the DOT OIG issued a report that detailed the results of a review of FAA actions to address allegations of leave and overtime abuse at five locations.¹⁵ The DOT OIG was

¹⁵ A copy of the 2004 DOT OIG report is contained in Appendix 4.

satisfied that abuses were being corrected at New York TRACON because of the implementation of a “test” program in March 2004. The DOT OIG was under the impression that this test would be implemented permanently. During the test, only OMs had the authority to approve overtime and schedule changes. During the test period, overtime hours dropped by 21 percent from the same period in 2003, producing a cost savings of \$142,000 in 10 weeks. After the test period ended, practices returned to pre-test methods, and overtime returned to 2003 levels. Eight days after management began to restrict overtime on January 26, 2005, the FAA began receiving numerous complaints of operational errors. At the same time, local NATCA officials made public allegations that understaffing was creating unsafe conditions at the facility.

Summary

Schedule manipulation, low time-on-position, excessive sick leave usage, and unusually high OWCP claims at New York TRACON continue to drive the high cost of operations at the facility. Although management has taken steps to control costs, several inefficient practices remain, including questionable scheduling and time-on-position practices, and use of sick leave and the OWCP.

Finding #6 Recommendations

27. New York TRACON facility management should design and manage controller shift schedules.
28. New York TRACON facility management should monitor the use of sick leave and take steps to curb abuse through the FAA Conduct and Discipline Order 3750.7, Ethical Conduct and Financial Disclosure Program, Appendix 6, Standards of Ethical Conduct.
29. The FAA should examine New York TRACON OWCP claims to determine the reasons for the large number of work hours lost.
30. The FAA should refer possible irregularities in the areas of OWCP, time-on-position, and scheduling practices to the DOT OIG for further review.
31. New York TRACON should implement automated SISO capability.

Finding #7: Despite a sharp decrease in traffic counts in the Islip area staffing levels have remained constant.

Maintenance of a separate Islip operational area at New York TRACON may no longer be needed because traffic counts in the Islip area have decreased significantly in the past several years. The low traffic volume leads to significantly higher operational costs in the Islip area as compared to other areas of the TRACON.

Changes in the industry fleet have eliminated the major traffic flows through the Islip area. Turbo-prop traffic has been largely replaced by Regional Jets. The Islip area was responsible for sequencing turbo-prop traffic from New England landing at JFK, LaGuardia, Newark, Teterboro, and White Plains airports. This traffic no longer exists. In 1991, the total traffic count was 287,094, or 787 operations per day. These traffic counts include instrument and visual traffic. The traffic has declined dramatically over the past several years, as shown in Figure 33 below. In FY 04, the total traffic count for the Islip area was 191,154, or an average of only 523 operations per day. During observations in the operating quarters, assessment team members observed, at times, more controllers on position than aircraft being controlled in the area.

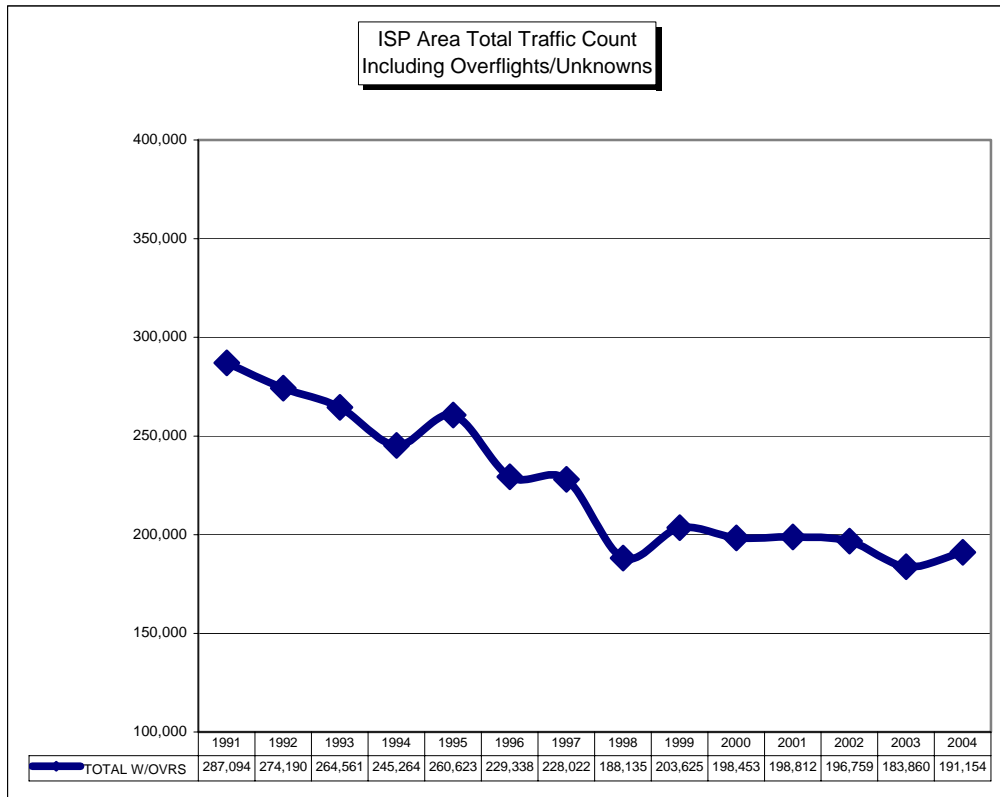


Figure 33. Islip Traffic Counts 1991-2004

Since instrument traffic is the majority of the overall air traffic workload at New York TRACON because of the Class B airspace, the team reviewed instrument traffic loads only when comparing other areas to the Islip area. Instrument traffic for the Islip area

was only 111,649 operations in 2004. Kennedy area had 359,579 instrument operations and Newark area had 668,267 instrument operations by comparison. The Islip area is authorized 45 controllers and had 38 onboard as of March 1, 2005. This high level of staffing and reduced traffic results in an operational cost per operation in the Islip area that is significantly higher than the cost per operation in other areas of New York TRACON. As indicated in Figure 34 below, the total cost per operation, including overtime, for the Islip (ISP) area is \$54.79, whereas the cost in the Kennedy (JFK) area, including overtime, was \$17.49 per operation, and the Newark (EWR) area, including overtime, was \$14.70 per operation.

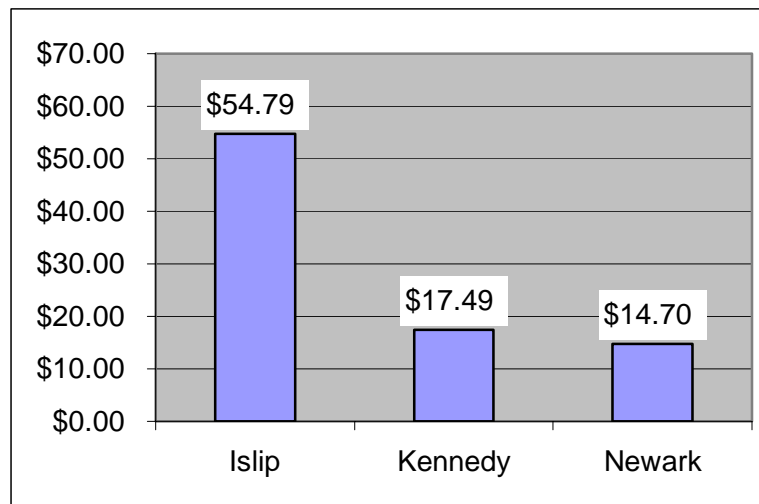


Figure 34. Overtime Costs in New York TRACON Operational Areas

In addition, the overtime costs associated with the ISP area for FY 04 were \$500,011, which equates to a unit overtime cost of \$2.62 per operation.

Because of the low traffic volume and the nature of the remaining traffic, options to consolidate Islip into other operational areas at New York TRACON or surrounding air traffic facilities should be explored. The facility has proposed that ISP area could be combined with the JFK area and handle Islip airport and Long Island traffic, the LGA area could handle White Plains traffic, and Bradley TRACON could handle Connecticut traffic. The facility estimates that, in the long term, elimination of the ISP area could allow re-allocation of personnel. This re-allocation could save as much as \$8.6 million annually for use elsewhere in New York TRACON.

Finding #7 Recommendations

32. New York TRACON facility management should complete a staff study to explore consolidation of the ISP area within the other operational areas within the facility and/or within surrounding facilities and reprogram staff to remaining operations. Timing of the ISP area changes should follow a period of stability in the other four areas at the New York TRACON.

Organizational Culture

Finding #8: A culture of insubordination and intimidation exists at the New York TRACON that requires management attention to prevent derogation of safety.

Although the initial task of the assessment team was to investigate the reports of operational errors on the Administrator's hotline, the team quickly discovered that labor-management relations at the facility were strained and could possibly explain the rash of hotline phone calls. Therefore, the team requested that the agency dispatch two human resources professionals to the site for the purpose of evaluating the working environment. To that end, over a period of ten days, the HR professionals conducted interviews of approximately 32 personnel, including 20 management officials (1st line supervisors, 2nd level supervisors/operational managers and staff supervisors); and 12 NATCA controllers (including the local union president and vice president). The personnel were questioned on topics relating to the controversy surrounding operational error reports, including: the overall facility environment; assignment of overtime and "credit hours"; perceived staffing requirements; the controller training program and the facility's "wash-out" rate for trainees; employee recognition; treatment of newcomers to the facility; and the effectiveness of the facility's acting manager and his relationship with the union local.

The union's insistence on being present during all such interviews inhibited the ability of the HR professionals to conduct a thorough investigation. The union also selected ten of the controllers who agreed to be interviewed. The interviews suggest a pattern of inappropriate conduct, including evidence of insubordination and intimidation directed at management. In particular, there was credible evidence of the following:

- The facility's Acting Manager has encountered a very difficult environment as he attempts to improve management within the facility. Unfortunately, there is very little communication between the president of the union and the Acting Manager, with most day-to-day labor relations issues being left to the grievance process. A recent union election for vice president, in which a group of controllers seeking reform of the union organized an active coalition against the incumbent, however, seems to be encouraging some dialogue between the union and management.
- Management's recent efforts to regain control over scheduling and thus to limit the use of overtime and credit hours had engendered significant resistance from several union representatives. In one instance during the assessment, when a supervisor confronted a union representative about falsifying time-on-position logs, the latter became hostile and belligerent, stalking the supervisor around the facility in a physically intimidating manner. In another instance a manager's decision to reduce the number of staff below union-negotiated levels (and hence to restrict overtime pay) resulted in a profanity-laced phone call from the local union representative who threatened that the manager might have to explain the decision to his "neighbors" "if something happened" during his watch; the following day the same officer confronted

the manager in an insubordinate and intimidating fashion at the workplace [*The documentation of these and other episodes can be found in Appendix 5 of this report.*]

- A basic lack of respect for management authority permeates the facility and presents operational supervisors with a challenging climate in the control room in particular. Union representatives openly controvert management decisions, arguing in public areas and using foul language. In fact, several interviewees said that profanity has become the norm on the radar floor, and several supervisors and controllers said they were offended by its use. Disputes over staffing levels and denial of overtime regularly spill over into the control room, suggesting a derogation of safety could occur.
- A sense of ‘entitlement’ exists over practices such as having regularly scheduled overtime, coming in to work on scheduled leave (which triggers overtime pay), coming in to earn credit hours without prior approval, and to an extent, taking medical leave for “stress” claims (OWCP). Managers felt that little could be done to curb these entitlements, given union control of the work schedule and overtime and preexisting “agreements” embodied in the so-called FACT minutes and local MOUs.
- A feeling of disdain exists for outsiders, especially for those in management. The general feeling was that, if a manager joined the facility from elsewhere in the FAA, then he or she would be ignorant about the operation of the facility regardless of air traffic experience. The position of administrative Operational Managers (OM’s) was an issue on both sides of the table. Controllers said they resented their 2nd level authority because they do not work on the radar floor. Other supervisors question their roles and responsibilities, which appear undefined.
- The working environment is poor. In particular, there was evidence in three interviews of females and minorities that the atmosphere fostered by the union makes them uncomfortable.

Finding #8 Recommendations

33. New York TRACON facility management should take immediate action to deal with any incidents of threats or intimidation at New York TRACON.
34. FAA management should direct facility management at New York TRACON to control all aspects of facility scheduling.
35. New York TRACON Operations Managers and Operational Supervisors should ensure that the control room is a sterile environment in which the focus is the sequence and separation of air traffic, and the provision of aviation information, navigation assistance, and landing information.
36. ATO’s Eastern Terminal Service Area should resolve the issue of who is going to manage New York TRACON.
37. ATO should implement a long-term strategy to improve labor relations and ensure solid operational performance.

38. Recommend turning all evidence of inappropriate behavior to the Inspector General's office.

Appendix 1

New York TRACON Safety Concerns Press Statements

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The New York Times

February 18, 2005 Friday
Late Edition - Final

SECTION: Section B; Column 1; Metropolitan Desk; Pg. 3

LENGTH: 817 words

HEADLINE: Errors by Air Controllers Rise Sharply in New York

BYLINE: By MATTHEW L. WALD

DATELINE: WASHINGTON, Feb. 17

BODY:

Air traffic controllers in New York have made errors that sent planes too close to each other many times in the last few weeks, at a rate at least six times higher than such errors occurred last year. The severity of the errors is not clear.

According to the controllers' union, the reason is a shortage of personnel, resulting from a cutback in overtime at the New York Terminal Radar Approach Control, or Tracon, a windowless building in Westbury, N.Y., from which controllers manage the flow in and out of airports in the areas. The National Air Traffic Controllers Association, which represents the controllers, and the Federal Aviation Administration have been in conflict for years over what constitutes adequate staffing.

An F.A.A. official, Rick Ducharme, said he did not know the reason for the increase in errors. On the staffing issue, he said that procedures had been changed in January, with the agency evaluating anticipated traffic levels, weather conditions and other factors in deciding how many controllers were needed for each shift. The agency is also trying to crack down on abuse of sick leave and other problems identified by the Transportation Department's inspector general last fall, said Mr. Ducharme, who is the director of Eastern Terminal Area Operations.

The new allegations appear to originate within the air traffic system. The inspector general of the Transportation Department maintains a confidential telephone line for anonymous reports of such "operational errors," and an assistant inspector general said the line had received 18 such reports in the last two weeks, each alleging multiple violations.

"We are directing inquiries into these allegations, and if substantiated, we would consider such a volume serious in nature," said Charles H. Lee Jr., assistant inspector general for investigations. The usual procedure is for the F.A.A. to replay the radar tapes that show aircraft positions.

According to the controllers and F.A.A. officials, there have been 19 confirmed errors since Jan. 1; in 2004 there were 24 for the whole year.

Mr. Ducharme said, "This is serious, this has me concerned," adding that "each operating error has to be analyzed." The actual number of violations would depend on many factors, including visibility. For planes lining up to land, if the tower controller can see both planes,

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1-1

he said, then separation of less than the standard 3 miles is acceptable.

"We'll get to the bottom of it eventually," he said. "I don't want to take a guess now of what my trends look like."

In a report last September on operational errors nationwide, the inspector general, Kenneth M. Mead, said that such violations, which air traffic controllers are supposed to identify themselves, were underreported, although it was difficult to say by how much.

On Thursday, Senators Hillary Rodham Clinton and Charles E. Schumer released a letter they had sent the previous day to the F.A.A. administrator, Marion C. Blakey, saying that the agency's decision to curtail overtime was "exacerbating an already dangerous situation."

"We believe that the staffing situation poses a threat to the flying public," the letter said.

The letter pointed out that a plan published by the agency last December promised that any shortage of controllers would be met "in the area of system capacity, not system safety," meaning that the number of flights would be cut back.

Dean Iacopelli, a controller who is the president of the union local at the **New York Tracon**, said that he was working on the night of Feb. 5 when another controller made an operational error. There were 9 people on shift at the time, he said, although there are usually 12.

Following regulations, the controller who made the error was taken off shift, Mr. Iacopelli said, and so was the supervisor, who was sent to investigate. That left seven on duty, he said, making the problem even worse.

According to the controllers, the number of arrivals, departures and overflights they handle grew 5 percent in January from the year earlier, to 186,000.

On Feb. 3, a letter signed by 226 of the controllers was sent to the F.A.A. administrator, Ms. Blakey, blaming the Tracon manager. The letter said the manager had embarked on "a reckless mission, directing his managers to operate with fewer controllers at a time when traffic is increasing." It added that the Tracon manager had "performance deficiencies" that superiors had corrected, until the manager, who is African-American, had "intimidated" higher-ups at the Tracon by filing an Equal Employment Opportunity complaint against them.

An F.A.A. spokeswoman, Laura J. Brown, said her agency would not confirm whether such a complaint had been filed, and would not make the manager available for comment. Mr. Ducharme said he had full confidence in the manager.

URL: <http://www.nytimes.com>

LOAD-DATE: February 18, 2005

◀ [prev](#) Document 8 of 9 [next](#) ▶

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Newsday

Newsday (New York)

February 18, 2005 Friday
ALL EDITIONS

SECTION: NEWS; Pg. A05

LENGTH: 461 words

HEADLINE: More reports of close calls in air

BYLINE: BY SYLVIA ADCOCK. STAFF WRITER

BODY:

Air traffic controllers in Westbury who guide planes in and out of New York area airports have logged more than a dozen mistakes that brought airplanes too close together in the five weeks since the Federal Aviation Administration cut back on overtime, the FAA confirmed yesterday.

Dean Iacopelli, an official of the air traffic controllers union that first publicized the numbers, said yesterday they indicated that the unit is "woefully understaffed."

On Jan. 12, FAA managers at the **New York TRACON**, or Terminal Radar Approach Control, cracked down on the use of "call-up" overtime - bringing a controller in on overtime to replace someone who called in sick or is on vacation.

Since then, 18 reports have been confirmed by the FAA as operational mistakes that allowed two planes to come too close together. In 2004, TRACON controllers only logged 24 mistakes, the union said. Under FAA rules, controllers at TRACON are generally not supposed to allow planes closer than three miles apart horizontally or 1,000 feet vertically. The errors reported in the past five weeks occurred most often when the planes were headed for runways at Kennedy, LaGuardia or Newark.

Iacopelli, president of the TRACON unit of the National Air Traffic Controllers Association, said the number shows the facility's "margin of safety is the lowest I've ever seen."

In most cases, the errors were anonymously reported to an FAA hotline.

This comes at a time when the union and the FAA are preparing for a contract battle. Rick Ducharme, the FAA's air traffic chief for the northeastern United States, said he was concerned about the spike in errors, but also worried about how they were reported.

"I don't believe we have a safety issue," Ducharme said.

But Iacopelli said "the fact remains that these are legitimate losses of separation."

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In September, the U.S. Department of Transportation's inspector general found that controllers at facilities like the TRACON don't always report their mistakes, as required.

Ducharme said the local unit leads the nation in overtime among FAA facilities, with \$1.4 million spent for the fiscal year that began Oct. 1. "We've put in management controls to utilize the taxpayer's dollar wisely," Ducharme said.

The union also has complained to lawmakers about TRACON staffing, and New York's two senators Wednesday sent a letter to FAA Administrator Marion Blakey. "We believe the staffing situation poses a threat to the flying public," says the letter from Sens. Hillary Rodham Clinton and Charles Schumer, both Democrats.

The FAA and the union agree the Westbury facility is short-staffed with 208 controllers, down five from the previous month. Meanwhile, the number of airplanes handled by the center has gone up by 5 percent over the same period last year.

GRAPHIC: Photo - Union official says Westbury unit "woefully understaffed."

LOAD-DATE: February 18, 2005

◀ [prev](#) Document 9 of 9

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Appendix 2

Severity Index for Operational Errors

***RADAR OE SEVERITY INDEX TERMINAL AND EN-ROUTE
SINGLE SITE CHART***

VERTICAL SEPARATION	POINTS	HORIZONTAL SEPARATION* 3-mile separation requirement	POINTS
Less than 500 feet	25	Less than ½ mile	25
500 feet to 599 feet	20	½ mile to 0.999 mile	18
600 feet to 699 feet	16	1 mile to 1.499 miles	14
700 feet to 799 feet	12	1.5 miles to 2 miles	10
800 feet to 899 feet	6	2 miles to 2.499 miles	6
900 feet to 999 feet	2	2.5 miles to 2.999 miles	2
CLOSURE RATE	POINTS	HORIZONTAL SEPARATION 2.5-mile requirement	POINTS
700 knots and greater	10	Less than ½ mile	25
300 knots to 699 knots	8	½ mile to 0.999 mile	20
100 knots to 299 knots	6	1 mile to 1.499 miles	16
Less than 100 knots	4	1.5 miles to 1.999 miles	10
FLIGHT PATHS	POINTS	2 miles to 2.499 miles	4
Converging – Opposite Courses	20	ATC CONTROL FACTOR	POINTS
Converging – Crossing Course	18	Uncontrolled	20
Same Course	10	Controlled with TCAS RA	15
Diverging/Non-Intersecting	0	Controlled with no TCAS RA	4

* When wake turbulence separation standards are governing, **DO NOT** include any vertical point value. Instead use the appropriate in trail separation index below, as well as other applicable factors.

IN TRAIL SEPARATION 4-mile separation requirement	POINTS	IN TRAIL SEPARATION 5-mile separation requirement	POINTS

3.499 miles and less	60	4.499 miles and less	60
3.5 miles to 3.999 miles	35	4.5 miles to 4.999 miles	35

IN TRAIL SEPARATION 6-mile separation requirement	POINTS
5.499 miles and less	60
5.5 miles to 5.999 miles	35

Appendix 3

**Methodology for
Selecting the Tape Reviews**

Methodology for Selecting the Tape Reviews

When the assessment began, the team asked the facility to retain all data until advised. The team determined that an audit was required to assess if the errors identified by the Hotline calls were anomalous or if they were also occurring at other times.

The assessment team decided to conduct tape reviews on a sample of four hours per day for 45 days. The tape reviews covered radar and voice data from February 1-March 17 for the JFK, LGA, EWR and LIB operational areas. The team selected the four hours using the following method.

- 180 hours were selected by choosing four hours for each of the 45 days.
 - Only 6 a.m. to 11 p.m. were covered.
 - Some of the hours were selected based on peak traffic times.
 - Some of the hours were selected to ensure that all shifts and time periods were covered.
- 60 hours were selected to cover:
 - All Hotline call time periods
 - Other time periods requested by the facility.

Appendix 4
Waste, Fraud, & Abuse
Reports




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

Memorandum

Subject: ACTION: Report on FAA's Actions To Address Allegations of Leave and Overtime Abuse at Five Locations
AV-2004-081

Date: September 9, 2004

From: Alexis M. Stefani 
Principal Assistant Inspector General
for Auditing and Evaluation

Reply to
Attn. of: JA-10

To: Federal Aviation Administrator

This report provides the results of our review of the Federal Aviation Administration's (FAA) actions to address allegations of leave and overtime abuse at five locations. The Department of Transportation Office of Inspector General (OIG) Hotline received several complaints alleging that FAA employees at five facilities were manipulating work schedules, sick leave, and annual leave to increase overtime payments. Specifically, the complaints alleged that employees at those locations were:

- Intentionally canceling sick leave after employees had been called in on overtime to backfill absences,
- Changing work schedules to earn both Sunday premium pay and overtime pay,
- Leaving as much as 4 hours before the end of their shift without taking leave, and
- Receiving credit hours for time not actually worked.

In March 2004, FAA's Deputy Administrator, the Air Traffic Organization's Chief Operating Officer and Vice President of Terminals, and FAA's Eastern Region Air Traffic Manager briefed the Inspector General on actions taken by the Agency to address issues contained in the hotline complaints at two of the named locations. At that meeting, it was agreed that the OIG would review actions taken at those two sites and expand the review to include the three other locations identified in the complaints.

The objectives of the review were to identify actions taken by Air Traffic management to (1) investigate the allegations of FAA employees manipulating work schedules, sick leave, and annual leave to increase overtime pay, and (2) implement new policies and procedures to curtail potential future abuse, if appropriate. The scope and methodology we used in conducting this review are detailed in Exhibit A. Specific allegations, investigative actions taken, and policies implemented by FAA are listed in Exhibit B.

RESULTS IN BRIEF

We found that FAA managers at the five locations had taken effective actions to determine if the allegations were valid and to address them as appropriate. At several of the locations, managers identified systemic patterns of potential abuse, such as employees requesting leave and then reporting for duty after employees had been called in on overtime to backfill absences. In response, managers at those locations implemented facility-wide policy changes to curtail future abuse, including limiting the authority of Controllers-In-Charge to approve overtime, schedule changes, or credit hours.

The measures taken by Air Traffic managers represent a significant change from actions taken by FAA in the past. In previous cases when we made FAA aware of similar hotline allegations, the Agency took little or no action to deter or prevent possible abuse or even to determine if the allegations were valid.

While the actions planned or taken at the five facilities are clearly steps in the right direction, it is important to recognize that they may not be representative of an Agency-wide trend. FAA has over 300 towers, terminal radar approach control facilities, and en route centers. At the five locations we visited, we observed that managers took an extra effort to collect the data needed to identify possible cases of abuse. However, that process is extremely labor intensive, and it is uncertain whether managers throughout the Agency are putting forth similar efforts.

The absence of an automated system that provides the information that managers need to adequately monitor leave and overtime usage underscores the need for FAA to have its labor distribution system in place and operating. FAA plans to begin implementing the system for the Air Traffic Organization in September 2004. As part of that deployment, we are recommending that FAA identify the specific information managers need to effectively monitor overtime and leave usage and ensure that the system will be able to capture the necessary data.

OBSERVATIONS

At the five facilities listed in the hotline complaints, we found that Air Traffic management was focused on assessing whether allegations in the complaints occurred and implementing policies and procedures to prevent future occurrences, where appropriate. For example, at all five locations, managers had implemented stronger controls over leave and overtime usage by limiting the authority of Controllers-In-Charge to approve overtime, schedule changes, or credit hours. According to FAA managers at one of the locations, in the first pay period alone, this change resulted in a reduction of over 360 hours in overtime, yielding an estimated savings of about \$30,000.

At three of the five locations, we found that FAA plans to open negotiations with the controllers' union to rescind an Eastern Region order from 1983 that allows controllers to earn both Sunday premium pay and overtime pay in the same week by simply changing their schedule on paper.¹

At three of the five locations, we also found that management had conducted an extensive review of sick leave usage. As a result of that review, approximately 40 controllers were sent letters requiring future use of sick leave to be documented by a physician's note.

In our opinion, the overall actions taken or planned by Air Traffic management at the five locations represent a significant change in direction from FAA's past actions. In several previous cases when we made FAA aware of similar hotline allegations, the Agency took little or no action to deter or prevent possible abuse or even to determine if the allegations were valid.

We did observe, however, that identifying potential cases of abuse required an extensive amount of effort by facility supervisors and staff. At the five locations, we found that managers developed elaborate internal systems to track workforce information so that they had the necessary data to identify potential cases of abuse. For example, we observed that managers at one facility manually entered time and attendance data into as many as three internally developed databases so that information was available to monitor overtime and leave usage.

At another location visited, we found that FAA is testing a new system called a "productivity worksheet" that recaps facility-wide data on information such as time-on-position, leave, overtime, breaks, and collateral duties. This new

¹ Employees cannot get both Sunday premium pay (125 percent of base pay) and overtime pay (150 percent of base pay) for the same day worked. Therefore by changing their schedules to reflect another day as their scheduled day off, employees would earn Sunday premium pay on the Sunday and overtime pay on another day during the workweek.

initiative, although still in the preliminary stages of development, is encouraging because it demonstrates that FAA is actively working to identify new methods for monitoring workforce-related issues and improving productivity. However, this process also requires data to be extracted manually from multiple sources.

At the five facilities we visited, managers had the necessary data to determine if allegations were valid because they manually collected that information. However, because the process is extremely labor intensive, it is uncertain whether all facility managers in FAA are putting forth similar efforts to collect the data needed to appropriately monitor overtime and leave usage. FAA has over 300 towers, terminal radar approach control facilities, and en route centers.

The absence of an automated system to collect the data managers need to adequately monitor leave and overtime usage underscores the need for FAA to have its labor distribution system in place and operating. That system could potentially be used to provide the necessary information needed to monitor overtime and leave usage.

However, FAA must first specify the data required by managers to identify potential cases of leave and overtime abuse and ascertain if the labor distribution system has the capability to provide it. If the system cannot provide the necessary data, then FAA needs to modify the system. FAA plans to begin implementing the labor distribution system in September 2004. As part of that deployment, we recommend that FAA identify the specific data needed for managers to effectively monitor overtime and leave usage and ensure that the labor distribution system will eventually be able to capture the data identified.

RECOMMENDATION

At the five facilities we visited, managers had the necessary information to determine if allegations were valid because they manually collected that information. However, because the process is extremely labor intensive, it is uncertain whether facility managers at other facilities are putting forth similar efforts to collect the data needed to appropriately monitor overtime and leave usage.

Accordingly, to ensure that FAA has Agency-wide tools for meeting those needs, we recommend that FAA identify the information that managers will need to monitor overtime and leave usage, determine whether the labor distribution system will capture the information identified, and modify the system as needed to ensure the appropriate information is captured and reported.

MANAGEMENT COMMENTS

On August 16, 2004, we met with the FAA Deputy Administrator to discuss the facts and recommendation in our draft report. We also provided a draft copy of our report to the Air Traffic Manager for FAA's Eastern Region. Both officials stated they generally agreed with the facts as presented in our report and concurred with the recommendation.

ACTIONS REQUIRED

In accordance with Department of Transportation Order 8000.1C, we would appreciate receiving your written comments within 30 calendar days. If you concur with the finding and recommendation, please indicate the specific action taken or planned for the recommendation and the target date for completion. If you do not concur, please provide your rationale. You may provide alternative courses of action that you believe would resolve the issues presented in this report.

We appreciate the cooperation and assistance provided by you and your staff during our review. If you have any questions or need further information, please contact me at (202) 366-1992 or David A. Dobbs, Assistant Inspector General for Aviation Audits, at (202) 366-0500.

#

cc: FAA Deputy Administrator
Air Traffic Chief Operating Officer
FAA Chief of Staff
Anthony Williams, ABU-100

EXHIBIT A. SCOPE AND METHODOLOGY

We conducted this review from April through August 2004 at the five facilities listed in the OIG Hotline complaints.

To determine what actions FAA had taken to investigate allegations of leave and overtime abuse, we interviewed managers at two regional headquarters and the five facilities identified in the hotline complaints. We reviewed the facility policies regarding overtime and leave approvals and discussed plans for new policies that outline potential abuses. We reviewed procedures taken at each facility to investigate the allegations, including actions taken after the initial responses to the allegations were received. Finally, we reviewed time and attendance data, as well as leave, overtime, and cost reports.

To identify actions taken by FAA management to implement new policies and procedures to curtail potential future abuse, we interviewed managers at two regional headquarters and the five facilities identified in the hotline complaints. We reviewed current policies and procedures used at each facility regarding the approval of overtime and leave. We also reviewed any planned actions by the facilities to address the allegations and future potential abuses. Finally, we reviewed productivity worksheets and memorandums of agreement to determine their effect on facility procedures.

We conducted this review in accordance with Government Auditing Standards prescribed by the Comptroller General of the United States and included such tests as we considered necessary to provide reasonable assurance of detecting abuse or illegal acts.

Exhibit A. Scope and Methodology

EXHIBIT B. HOTLINE ALLEGATIONS AND FAA ACTIONS

Allegation: Employees intentionally cancelled sick leave after employees had been called in on overtime to backfill their absence.

Actions Taken by FAA: At the five facilities we visited, managers stated that they investigated the hotline allegations by reviewing time and attendance and sign-in and sign-out logs. For example, one regional air traffic manager directed all facility managers in his region to conduct a review, which identified multiple instances of employees requesting sick leave and then reporting for duty after backfill overtime had been authorized. In those instances, contractual requirements allow both employees to work the full shift. At other locations, managers reviewed time and attendance data but did not find similar patterns of potential systemic abuse.

Policies and Procedures Implemented by FAA: All five facilities we visited had current or planned policies and procedures that require a supervisor or operations manager to approve backfill overtime. For example, at one facility new procedures are being tested that require operations managers to approve overtime rather than the Controllers-In-Charge. According to FAA managers, after one pay period, overtime was reduced by 362 hours, yielding an estimated savings of \$30,000. At another facility, managers told us that similar procedures have been in place for 3 years.

At three of the five locations, we also found that management had conducted an extensive review of sick leave usage. As a result of that review, approximately 40 controllers were sent letters requiring future use of sick leave to be documented by a physician's note.

Allegation: Employees changed work schedules so that both Sunday premium and overtime pay were earned.

Actions Taken by FAA: At one of the five facilities visited, facility managers reviewed payroll printouts to determine which employees earned Sunday premium pay and overtime pay during the same week. These records were further reviewed to determine if this happened due to a change in work schedule. However, no instances were found where work schedules were specifically changed so that employees could earn both Sunday premium pay and overtime pay.

Exhibit B. Hotline Allegations and FAA Actions

FAA's Eastern Region, however, has a Regional order dating from 1983 that stipulates that employees who regularly work 6-day work weeks should have their work schedules changed to reflect Sunday as a regular workday and another day as their overtime day. This allows employees to receive both overtime pay and Sunday premium pay by manipulating their scheduled workshifts.

Policies and Procedures Implemented by FAA: The FAA Administrator stated that the Eastern Region order is not consistent with FAA policy, and the Agency plans to open negotiations with the union to rescind the order.

Allegation: Employees left as much as 4 hours before the end of their shift without taking leave.

Actions Taken by FAA: Managers investigated the allegations by comparing sign-in and sign-out logs to when an employee actually logged onto or signed off of an operational position. At one region, facility managers investigated the allegation and found instances where extended periods of time had elapsed between the time a controller actually signed out of an active position controlling aircraft and when the controller's shift ended. However, specific instances of abuse were not found and management plans to continue monitoring the situation. At another region, the air traffic manager interviewed operations managers and found that no bargaining unit employees had been unaccounted for during their scheduled shifts.

Policies and Procedures Implemented by FAA: All five facilities visited have policies and procedures holding supervisors and operations managers accountable for knowing the location of their employees throughout the work shift. In addition, FAA is testing a new tool called a "productivity worksheet" that recaps facility information, such as the amount of time an air traffic controller spends actually controlling aircraft. One of the facilities we visited is a test facility for this project.

Allegation: Credit hours were approved for hours not actually worked.

Actions Taken by FAA: At three of the five facilities we visited, managers compared payroll reports to position sign-on logs to determine if controllers worked an operational position while earning credit hours. At one region, facility managers found instances where some controllers received credit hours while not controlling aircraft or performing other controller duties. In another region, a random sample of position sign-on logs showed that controllers were working operational positions while earning credit hours.

Exhibit B. Hotline Allegations and FAA Actions

Policies and Procedures Implemented by FAA: All five facilities visited have policies and procedures governing the credit hour program. However, three of the five facilities issued new policies restricting the authority to approve credit hours. For example, at one facility, authorization by a supervisor or operations manager is required to earn credit hours. Additionally, at three locations, management limited when credit hours could be earned and identified the specific activities that would qualify for earning credit hours.

Exhibit B. Hotline Allegations and FAA Actions

4-9

4-10

Appendix 5

Reports of Intimidation & Insubordination

On March 5, 2005 I was on duty as an Operations Manager during the 1500-2300 shift. From 1500 lcl, I was sitting at the Kennedy Area Operations Supervisors desk observing the area's operation.

At 1610lcl, OS [name removed] and CPC [name removed] were discussing Sunday Morning's staffing numbers with me. During this discussion, CPC [name removed] was standing at the desk and listening to the conversation. No determination for overtime for Sunday was made because the staffing numbers were going to change once a CPC completes an over-the-shoulder this evening. We will review this again later.

As everyone moved away from the desk, CPC [name removed], myself and CPC [name removed] were left. CPC [name removed] didn't agree with my decision and wanted to continue discussing the matter. I told him we are not discussing it any further until the outcome of the over the shoulder. He persisted in continuing the discussion and wanted an answer considering the over the shoulder was completed. I said no. At this point, CPC [name removed] asked how many Operations Managers are working tonight. My reply was "what does that have to do with anything". I answered his question anyway. At this point, CPC [name removed] was upset and moved closer to me and said "he does not give a [expletive] and [expletive] you". I told him to stop talking to me that way and I don't have to tolerate that behavior. CPC [name removed] now moves away from the desk. CPC [name removed] now smiles and says what behavior and walked away. I asked CPC [name removed] if he heard what CPC [name removed] had said. His answer was no.

I called the guard shack to have an officer meet me to remove CPC [name removed] if needed. the officer and I, met CPC [name removed] and informed him that he is relieved of his duties for the rest of the shift.

This is the second such incident for CPC [name removed]. Last evening he called me at Operations Desk on [phone number] line and used the same inappropriate language with me. A tape has been made of this conversation. This time however, it occurred in the work environment and is causing a hostile work environment.

Prepared by

[Name removed], Operations Manager

Memorandum for the Record

Discussions and Events Pertaining to (name removed) OS-JFK.

Just before 5:30pm I was working the supervisor position in the JFK Area. The Sequencer position was combined to the supervisor's position and (name removed) was receiving training from me on that position.

(name removed) had requested early in the shift to have the same dinner break as (name removed). (name removed) was added to the dinner break request some time after the shift began. (name removed) was working a 1x9, (name removed) a 2x10 shift.

Two controllers returned from a break and I decided to have them relieve (name removed) and (name removed) so they could go out to dinner together. (name removed) said he requested to eat at 6pm or after. I said he was already on position about 1 hour 15 minutes and if I waited until later, he would be on position too long.

(name removed) said the reason he asked for that meal period was because he needed to make a phone call between 6:30 and 7pm. I said if he was on a radar position he could ask to be relieved to use the men's room and make his phone call at that time. He lightheartedly asked me if I wanted him to lie (this is a reference to previous conversations between (name removed) and me in which I've said I would not lie about staffing needs) and I said well then ask to be relieved to make a phone call and I would be glad to relieve him.

(name removed) said that (name removed) had also requested to eat with him and (name removed). I said I did not have another person due back from break until 5:48pm. He asked if it would be okay if they waited for (name removed). I said it would be okay since no one else was on position very long. (name removed) came back from his break earlier than expected, at approximately 5:38pm, and he relieved (name removed) from Departure radar at which point (name removed) (name removed) and (name removed) all began their dinner break.

A few minutes later, I was updating the roster and went over to the Departure position to get the actual time (name removed) had signed on position. I picked up the Departure H/O log by mistake and noticed that (name removed) was signed on the log from 2227 to 2254Z. The entry was questionable since Departure H/O had at no time been open while I was on the floor.

I looked at logs from the other positions that had not been opened all evening. I saw that (name removed) had also apparently signed on J223, the second Flight Data position (2059-2114Z). (name removed) has signed on Rober H/O (2100-2114Z) and (name removed) had also signed on Departure H/O (2130-2148Z). (Coincidentally, the previous evening, my roster had shown (name removed) getting on position at 2000Z while he had signed on Camm H/O at 1945Z. I asked (name removed) while he was sitting on the position if he really got on there at 1945Z. He said he had come back early from his

break and was helping (name removed) who was working Final so obviously he was not on Camm H/O 1945Z.) When (name removed) returned from his lunch break, I asked him if he or someone else might have assigned these individuals to these positions and he said no.

I advised (name removed) the JFK Area Manager, that I was going to speak to (name removed) regarding questionable entries on position logs.

When the three individuals returned from dinner I asked to speak to (name removed) behind the scopes. I told him I was going to ask him about the logs, that this would be a Weingarten meeting, and that he was entitled to union representation. He said he didn't need a union rep unless the discussion could result in disciplinary action. I said that it could, (name removed) then became angry and asked who was putting me up to this. He said I didn't know what I was doing; that I was getting in over my head, that a phone call we had about a week earlier could be made public and cause me embarrassment. He began to ask questions about the logs and I told him that I would continue to discuss it without his rep as long as he knew that he was waiving his right to representation. He angrily responded that he didn't know if a rep was available and that I should help him find one. I told him that was not my responsibility. He then ordered me to get a room and to do it quickly, I told him a room would be available. I told him my actions were solely my own. I also told him I had tried to be honest and open with him while respecting the confidentiality of management conversations and meetings but that I wasn't getting honesty in return from him. He indicated that I would regret this. I told him that I fully expected he would use every weapon at his disposal against me.

(name removed) Meeting

At 7:10pm I met with (name removed) and his rep (name removed) in the upstairs conference room.

I showed him the two logs. Dept. H/O (J215) and Flight Data 2 (J223) and asked him if he could explain the entries. He said the times on the logs didn't make sense, that he couldn't remember, that the handwriting didn't look like his, and then that the handwriting on one of the logs looked like his. He then said the entry on J215 was his. I asked him if he had also signed off that log and he said that he couldn't remember. I asked him why he made that entry. He said that when he asked if he and (name removed) could wait for (name removed) and I agreed to that, he then asked if he could sign on Dept. H/O and I said yes. I said that he did not ask to sign on Dept H/O, that this was a lie. (I have as yet been unable to determine exactly when (name removed) signed on Dept and the three left for dinner because that log has disappeared.) He said he's got people in the area who will swear that's what happened, and added, "What have you got?" He, in fact, waited for (name removed) at the supervisor's desk where I was standing, still training the developmental.

I asked about the other log (J223). He said he had answered that twice. I asked again, since there was some confusion about which log was which, for clarification about the other log. He said he had already answered that twice. I asked again, since it was important that I be clear on this, and he again said that he had already answered that twice and that he couldn't help it if I was so stupid that I didn't get it. I said that may be true but I still needed clarification. I asked if he was refusing to answer my question and he said he had already answered the question. I asked him what then was his response when, as he said, he answered it before. He would not respond.

I told (name removed) that I did not want to go the route of disciplinary action but I couldn't have people signing on positions they were not assigned to. He said it was "too late to end this right here and now. You've made your decision. Now you've got to live with it."

I said I was done with the inquiry. He asked what I wanted him to do and I said he should return to the area. He said he needed to consult with his union rep first. I said that would be fine.

The meeting lasted approximately five minutes and ended at 7:15pm. I took notes during this inquiry (name removed) took no notes.

Confrontation in the JFK Area

At 8:05pm I returned to the area and prepared to leave for the evening.

I asked to speak to (name removed) privately to brief him on what had transpired. We went behind the scopes, near the Liberty Area mailboxes, (name removed) followed us and stood directly behind (name removed) within a couple of feet of him. I wasn't sure what prompted him to do that but we couldn't talk privately there so (name removed) and I moved over behind the sups desk. (name removed) followed us there as well. It was clear then that (name removed) actions were meant to provoke and physically intimidate.

(name removed) indicated that this was a private conversation. (name removed) said there were no private conversations on the operating room floor. Three times I calmly told (name removed) "I am directing you to move somewhere else." Three times he refused each time citing some other reason. He said that I had signed out for the evening and that I couldn't tell him to do anything, that (name removed) should be out front watching the area (name removed) told him that he had given the back to (name removed) who was now the CIC). His behavior was extremely aggressive, both verbally and physically. (name removed) attempted to diffuse the situation suggesting, "let's take a step back," (name removed) clearly was not interested in calming the situation. He said that I was going to drag all the sups into this and that they had me to blame. (name removed) and I, having both been relieved, left the area.

(name removed) and I together briefed (name removed) and (name removed) in detail. We all agreed that, most immediately, if this behavior continued (name removed) should be removed from the operations room.

Beyond that (name removed) insubordination, falsification of official documents, refusal to cooperate in an investigation, untruthful statements during an investigation, and creation of an intimidating, hostile environment, should be vigorously pursued.

This is my best recollection of the events of 3/2/05.

To: (name removed), OM
From: (name removed), OS JFK
Subject: Event in the JFK area
Date: March 3, 2005

(name removed),

On the evening of March 2nd at approximately 8:05pm in the JFK area I witnessed the following:

(name removed) OS asked to speak with me in private, I gave (name removed) a position relief briefing and proceeded behind the radarscopes by the mailboxes with (name removed).

As (name removed) and I started the conversation I noticed (name removed) standing within a couple of feet of me and (name removed). We could not continue our private conversation so we moved behind the JFK area sups desk. (name removed) followed us there as well and just stood within a couple of feet from (name removed) and me and stared at us.

I told (name removed) that this was a private conversation, he indicated that there were no private conversations here. At least twice (name removed) directed (name removed) to move somewhere else, he refused each time. (name removed) indicated to (name removed) that her shift was over and she could not tell him what to do and that I should be watching the area.

I told (name removed) that I had given the area to (name removed) and that he (name removed) should take a step back and reconsider his behavior, (name removed) then said that he was going to drag all the sups in this and (name removed) was to blame.

(name removed) and I left the area and met (name removed) and (name removed) to explain what had transpired.

Prepared by

(name removed), JFK OS

Appendix 6

Overtime & Credit Hour Agreement Memorandums



U.S. Department
of Transportation
**Federal Aviation
Administration**

Memorandum

Subject: **INFORMATION:** Credit Hours

Date: JUL -6 2004

From: Acting Air Traffic Manager, New York TRACON Reply to
Attn. of:

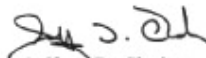
To: All Employees, New York TRACON

On June 10, 2004, I issued a memorandum stating all procedures for earning credit hours in conjunction with any particular shift(s) on a recurring basis would be terminated in 28 days.

Our current Memorandum of Understanding (MOU) on the Credit Hour Policy still allows for the earning of credit hours. All sections of this MOU, except for section 9, remain in effect.

Effective July 9, 2004, all requests to earn credit hours will continue to be presented to the OSIC/CIC.

The OSIC/CIC must receive approval from the OMIC prior to approving any requests to earn credit hours after July 8, 2004.


Jeffrey D. Clarke



U.S. Department
of Transportation
**Federal Aviation
Administration**

Memorandum

Subject: **INFORMATION:** Cancellation of Credit Hour
Agreement

Date: JUN 10 2004

From: Acting Air Traffic Manager, New York TRACON

Reply to
Attn. of:

To: All Employees, New York TRACON

Effective 28 days from the receipt of this memorandum, all procedures for earning credit hours in conjunction with any particular shift(s) on a recurring basis are terminated. In rendering this decision, we are exercising management's rights in accordance with Article 34, Section 8, of the collective bargaining agreement.


For Jeffrey D. Clarke



U.S. Department
of Transportation
**Federal Aviation
Administration**

Memorandum

Subject: **INFORMATION:** Procedures for Developing
Watch Schedules

Date: March 9, 2004

From: Operations Manager, Islip Area

Reply to
Attn. of:

To: Article 17 Schedule Maker and Schedule
Supervisor, Islip Area

Effective immediately, the following shall apply when developing area watch schedules:

- a. Employees shall not be scheduled for any leave in excess of their current balance plus any additional leave they may earn in the remainder of the leave year. Also, you are not authorized to approve leave of any type.
- b. Non- prime time annual leave shall not be scheduled on Tuesdays.
- c. Overtime shall not automatically be scheduled to back up prime time leave. No overtime shall be used to back up non-prime time leave.
- d. Training teams shall be scheduled for 11x7 shifts. The area Article 17 training person shall be scheduled for an 11x7 shift, unless otherwise coordinated with myself.
- e. Commencing April 20, 2004, schedule ACT teams to meet every other Tuesday. ACT teams shall be scheduled for 7x3 shifts.
- f. Once you have completed the draft schedule, forward it to me at least two weeks prior to the required posting date. At that time, also provide a current listing of all annual leave requests, along with a summary of individual prime time leave used to date, and any unusual leave requests (jury duty, FMLA, etc.). After I review the schedule, I will approve it and post it in the area.

Douglas C. Alter



U.S. Department
of Transportation
**Federal Aviation
Administration**

Memorandum

Subject: **ACTION:** Approval For Call-Up Overtime

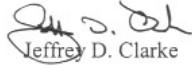
Date: **JAN 18 2005**

From: Acting Air Traffic Manager, New York TRACON

Reply to
Attn. of:

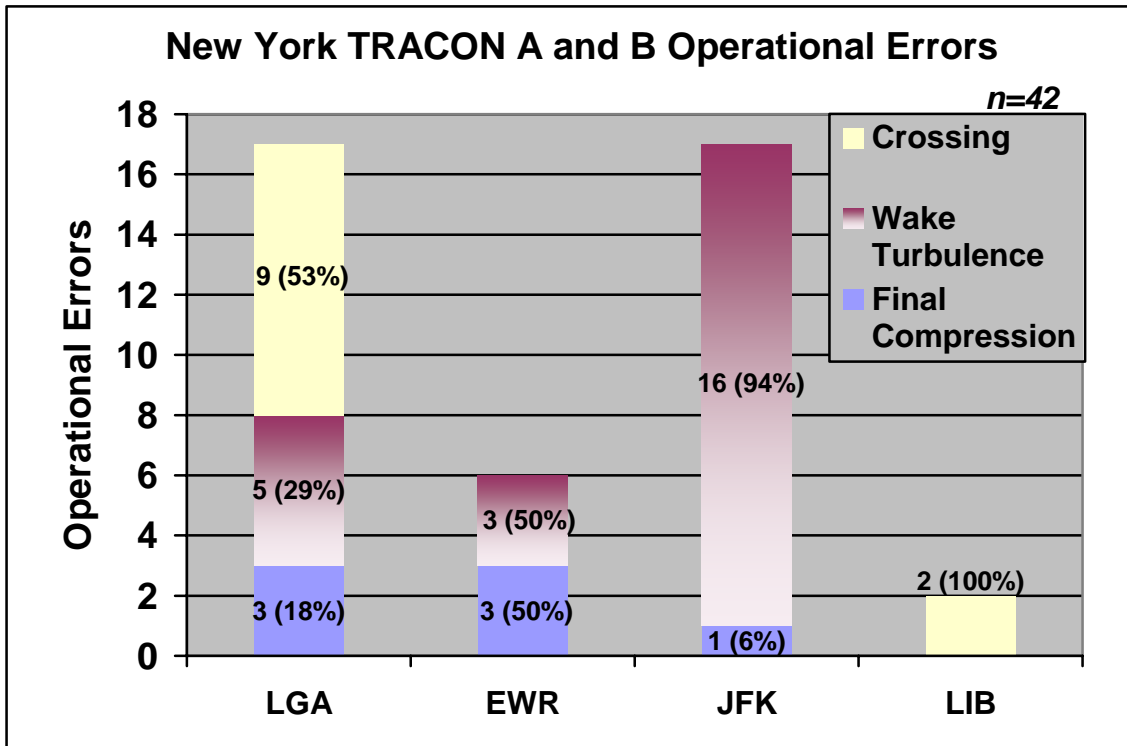
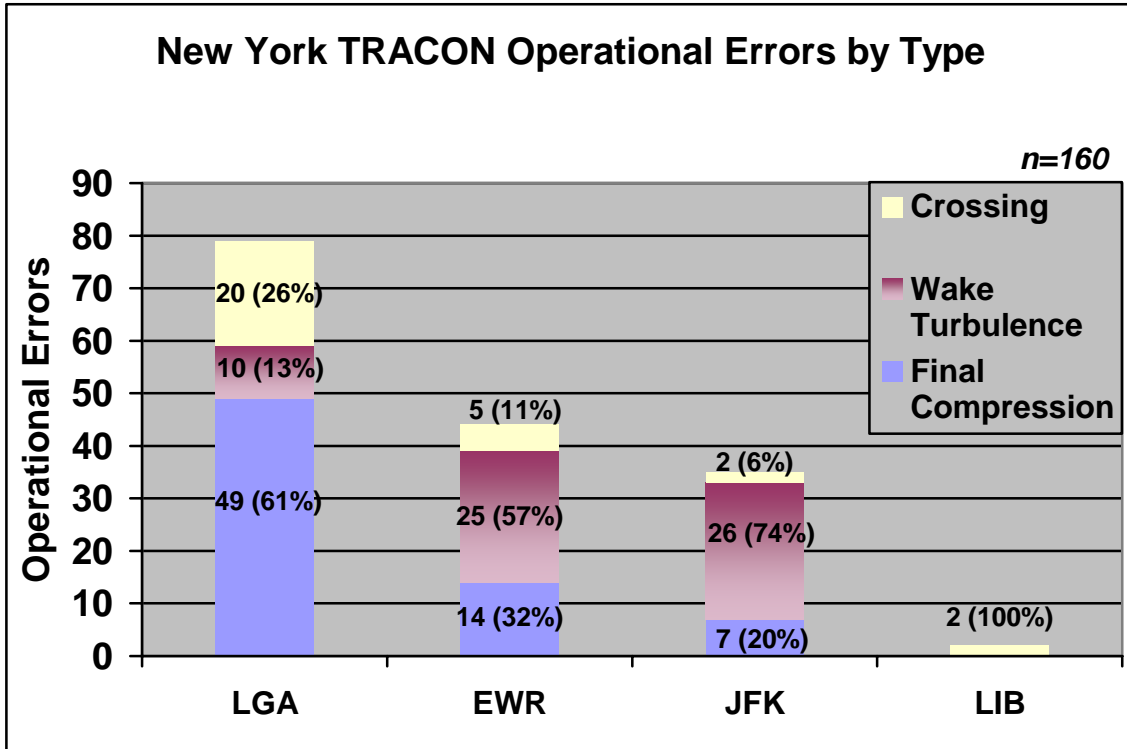
To: All Operations Managers, Supervisors, and CIC's

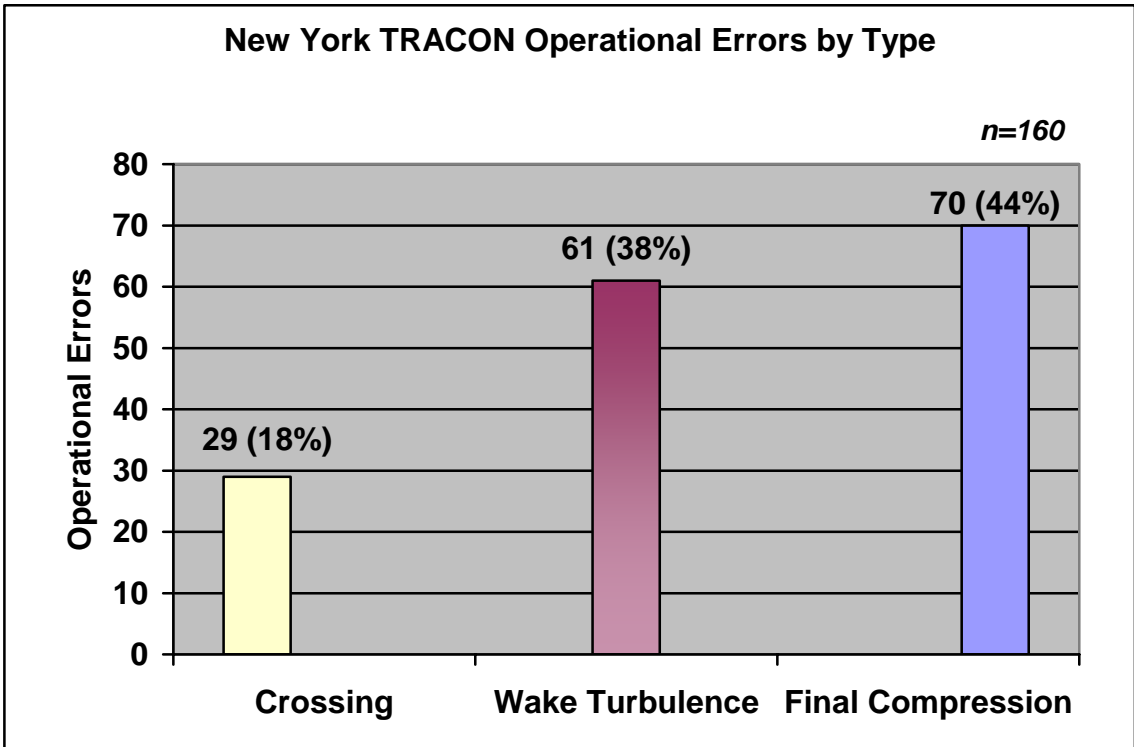
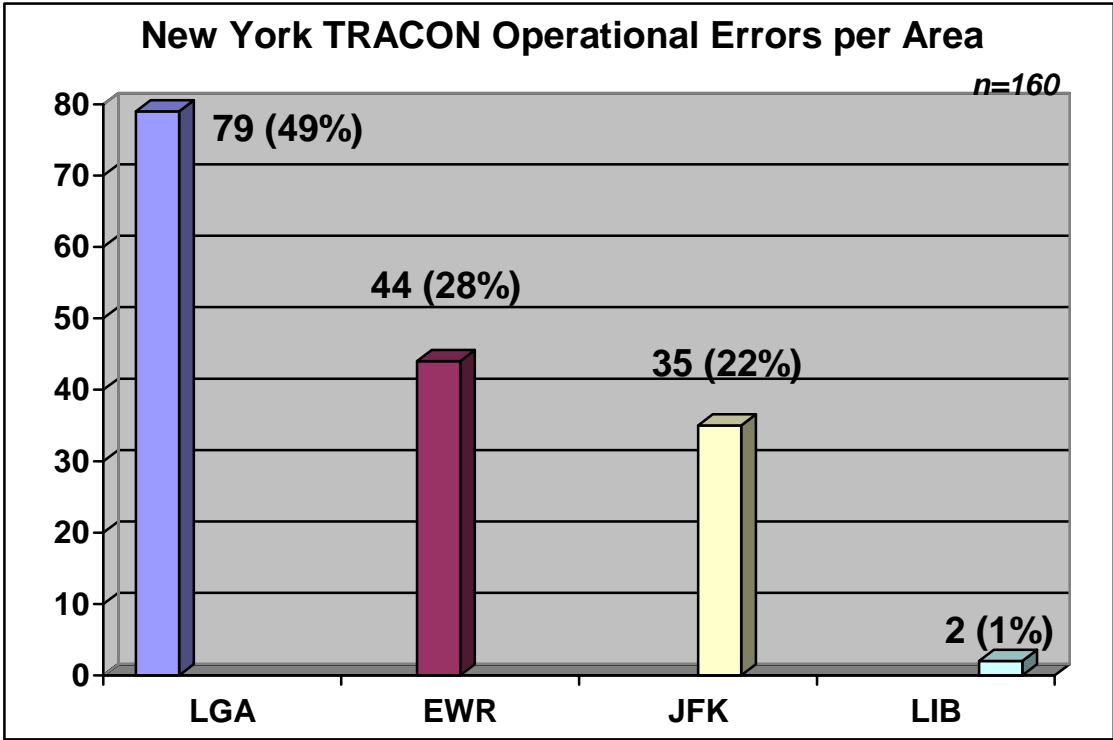
Effective immediately, any unscheduled call-up overtime must be approved by the Operations Manager-In-Charge (OMIC). When it is determined that call-up overtime may be necessary, the Operations Supervisor/CIC shall make the request for approval to the OMIC at the watch desk. During the midnight shift, the supervisor at the watch desk is fulfilling the duties of the OMIC.

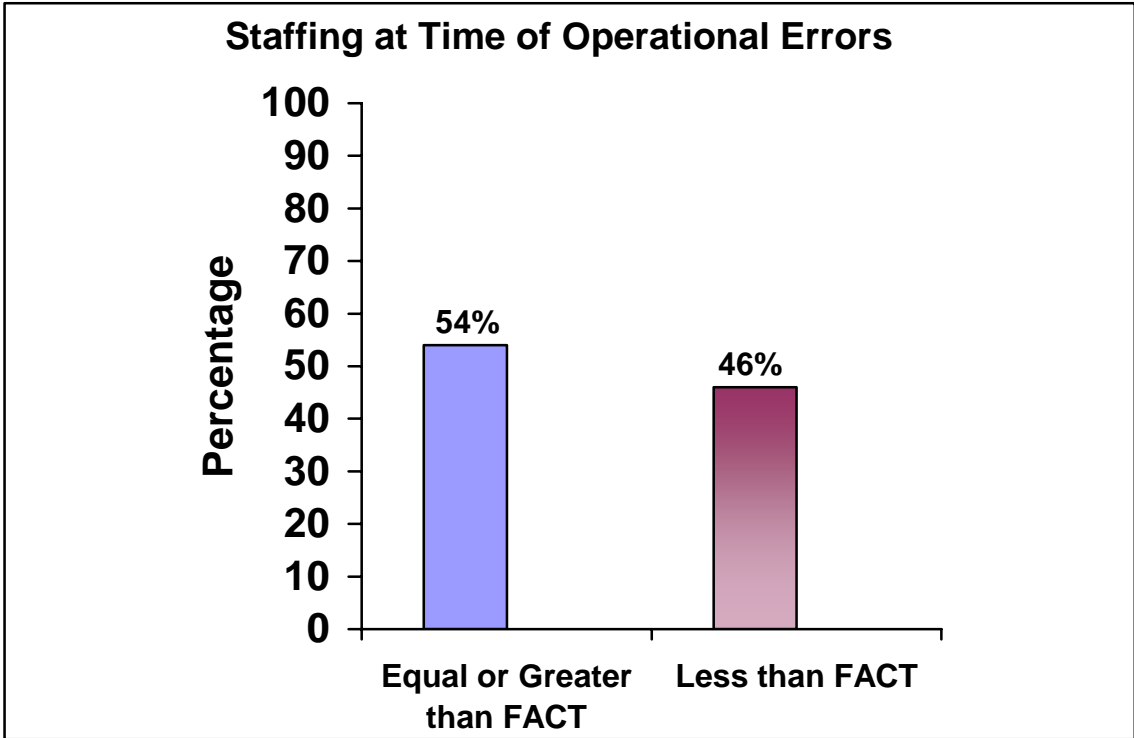
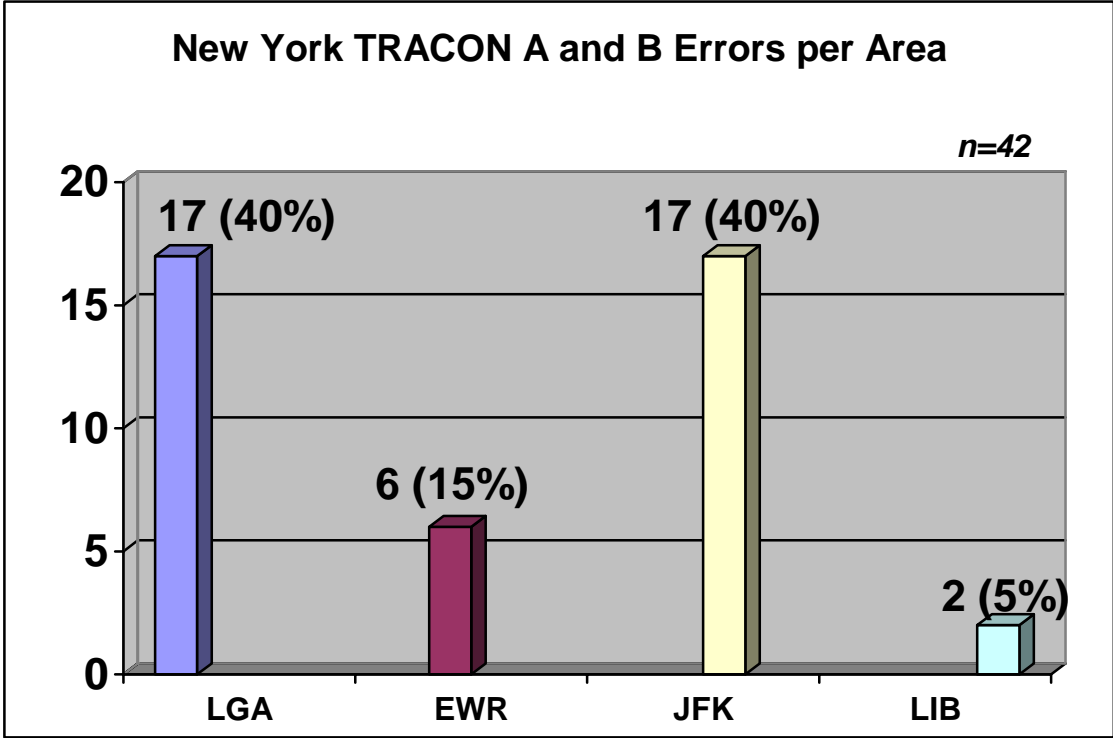

Jeffrey D. Clarke

Appendix 7
Supplementary Data

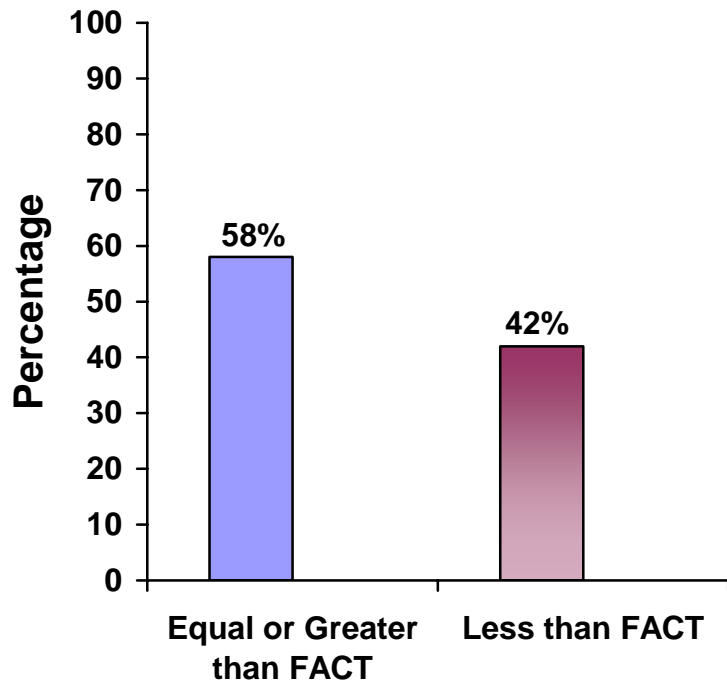
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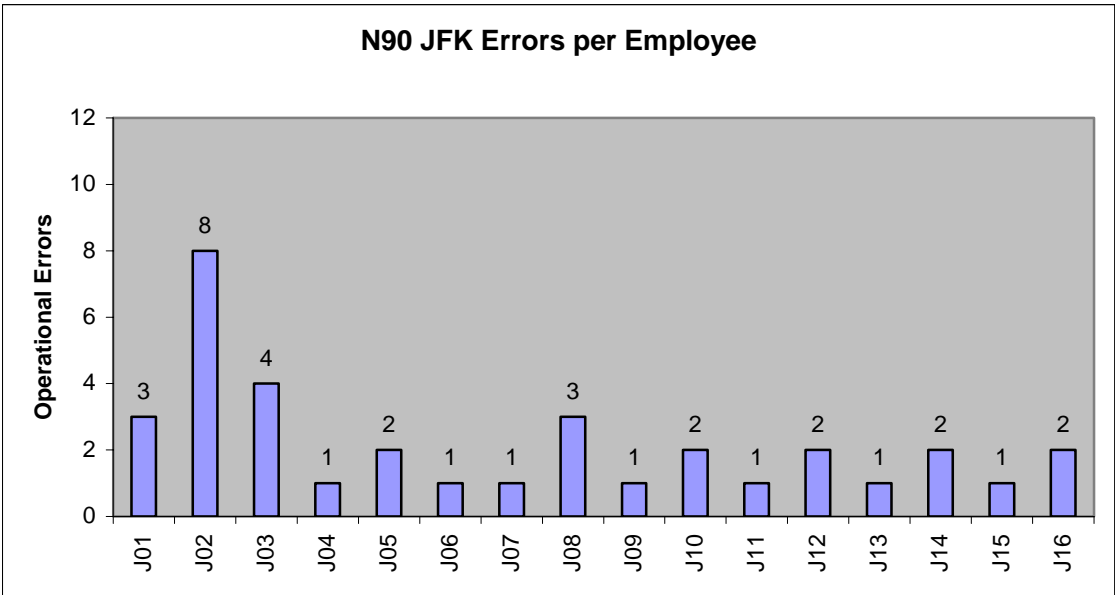
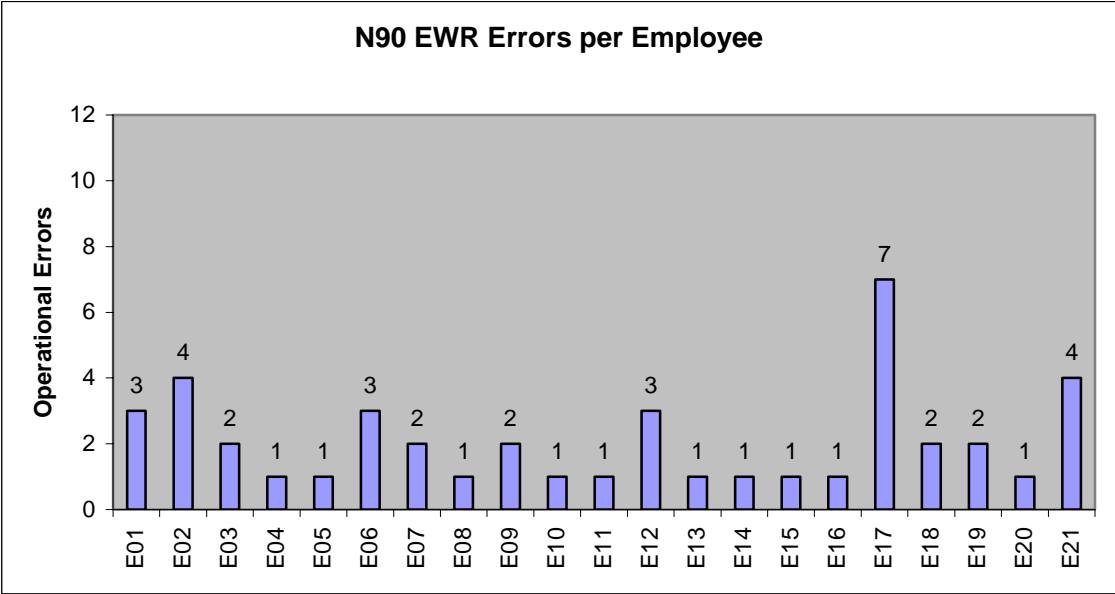




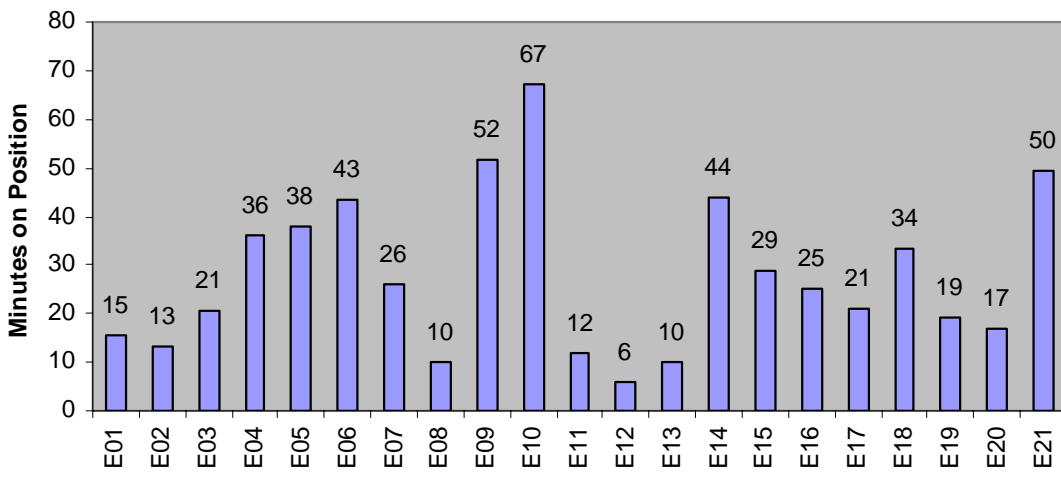


Staffing at Time of Category A & B Errors

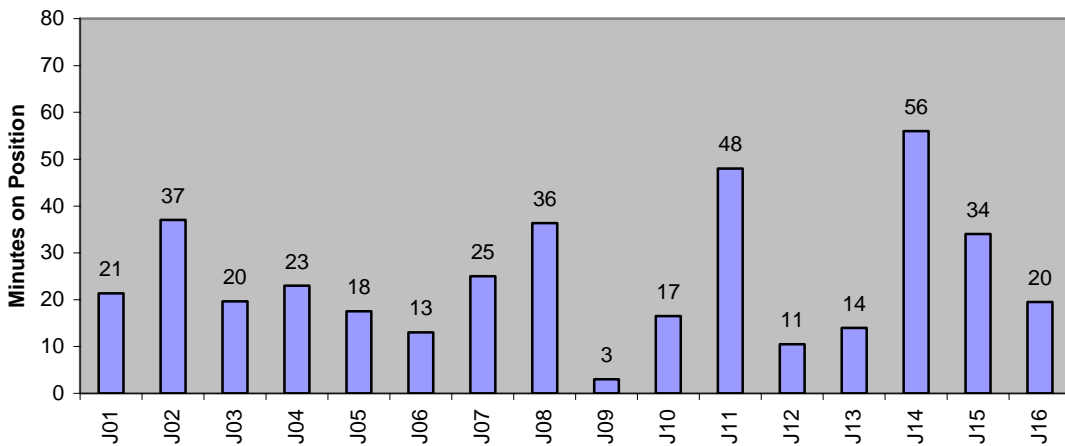


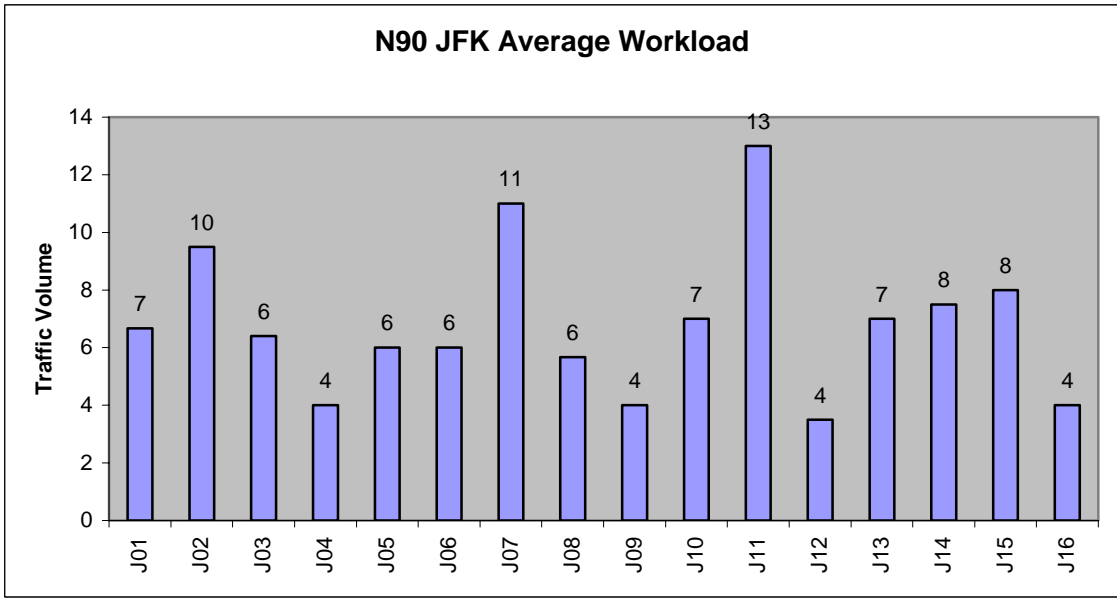
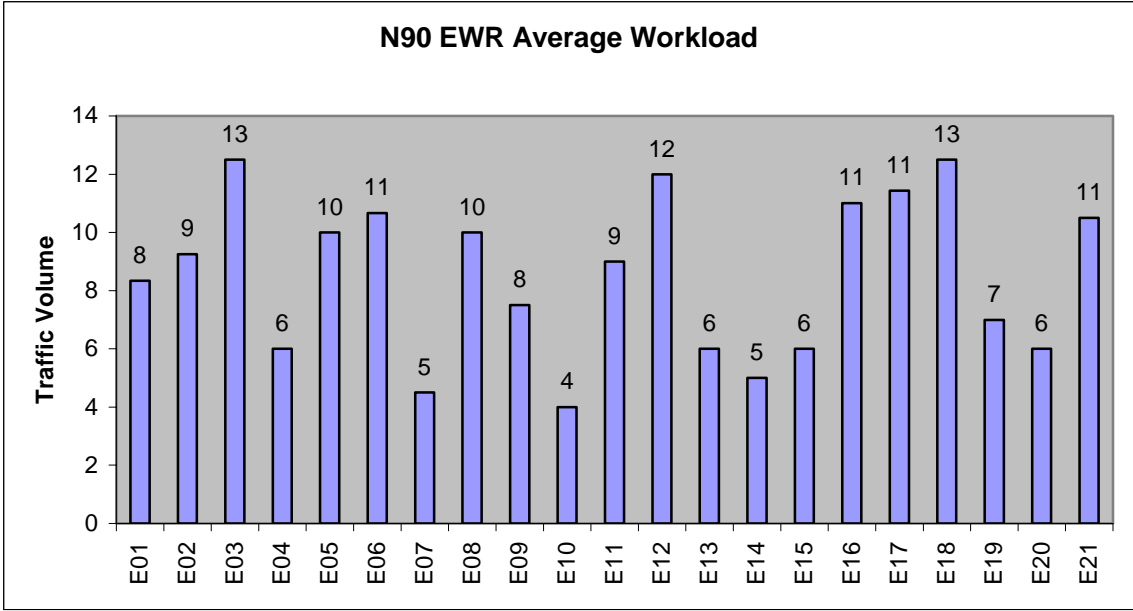


N90 EWR Average Time on Position

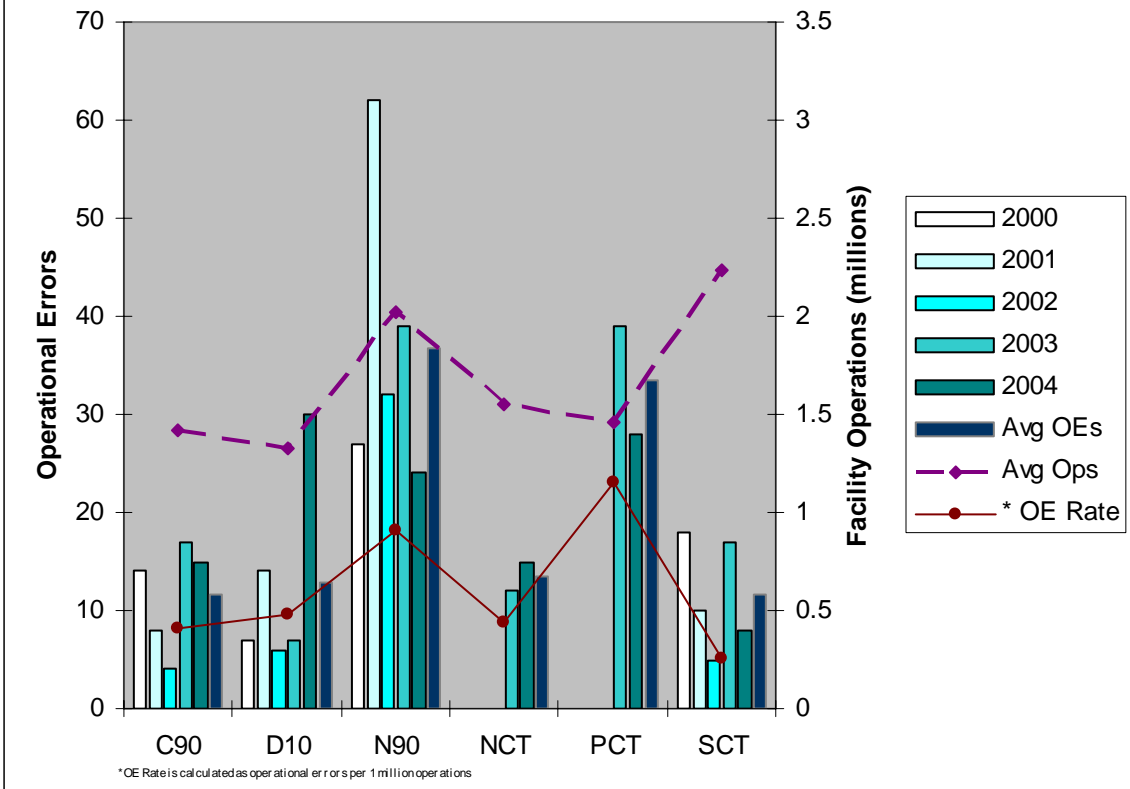


N90 JFK Average Time on Position





TRACON OE Comparison Fiscal Year 2000 - 2004



Appendix 8
Acronym List

Acronym List

ACT	Area Cooperative Team
ATC	Air Traffic Control
ATM	Air Traffic Manager
ATO	Air Traffic Organization
ATO-Finance	Air Traffic Organization Finance Service
ATO-Safety	Air Traffic Organization Safety Service
ATO-Terminal	Air Traffic Organization Terminal Services
C90	Chicago TRACON
CBA	Collective Bargaining Agreement
CIC	Controller in Charge
COP	Continuation of Pay
CPC	Certified Professional Controller
D10	Dallas/Fort Worth TRACON
DOT	Department of Transportation
EWR	EWR Area of Specialization at New York TRACON
FAA	Federal Aviation Administration
FACT	Facility Cooperative Team
FPL	Full Performance Level Controller
FY	Fiscal Year
IFR	Instrument Flight Rules
ISP	Islip Area of Specialization at New York TRACON
JFK	Kennedy Area of Specialization at New York TRACON
LGA	LaGuardia Area of Specialization at New York TRACON
LIB	Liberty Area of Specialization at New York TRACON
MOU	Memorandum of Understanding
N90	New York TRACON
NAS	National Airspace System
NATCA	National Air Traffic Controllers Association
NCT	Northern California TRACON
OE	Operational Error
OE/D	Operation Error/Deviation
OIG	Office of Inspector General
OM	Operations Manager
OMIC	Operational Manager-in-Charge
OS	Operational Supervisor
OWCP	Occupational Workman's Compensation Program
PCT	Potomac Consolidated TRACON
PQ	Partially Qualified Controller
QA	Quality Assurance
QAR	Quality Assurance Review
QTP	Quality Through Partnership
RA	Resolution Advisory
RAPTOR	Radar Audio Playback Terminal Operation Recording
SCT	Southern California TRACON

SISO	Sign In Sign Out
TCAS	Traffic Alert and Collision Avoidance System
TOP	Time-on-Position
TRACON	Terminal Radar Approach Control
TTD	Technical Training Discussion