

March 08, 2011

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

Re: OSC File No. DI-08-3138

Dear Ms. Gorman,

Thank-you for providing the opportunity for me to comment on the Department of Transportation's response to your third supplemental information request; as well as for your continued actions in pursuing these matters. Although I have not seen your actual request in this regard, I understand that five of the six reports you requested were provided. I have reviewed the reports that were provided. The first four reports speak to repeated improprieties and management malfeasance at DTW resulting in administrative actions unrelated to my allegations, except that Mr. Figliuolo, Ms. Bolard, and perhaps others, are implicated in those, as well as that of my allegations.

The fifth report is the long requested Quality Control Review completed by the Central Service Center. I can see why they did not want to provide it to me.

Most notably, although it indicates that the review included that of "radar and voice data from the 45 days prior to the teams visit," only the Operational Errors (OE) and Deviations (OD) that I brought to their attention are reported by them. As they indicate on page two of the report, I had provided the dates and times of just a handful of sample sessions in which multiple errors and deviations were substantiated. That was by no means an all inclusive review, included observations of a very small portion of a 17 day period, and resulted in the reporting of eleven Operational Deviations and three Operational Errors. These are the only events reported during this QCR. Why? I provided information on just a few, short periods of traffic as an example of how widespread was the noncompliance. A review of the 45 day period that was asserted to take place should have resulted in the reporting of many, many, many more. Why were these events not reported? In a single, short February 16 session of traffic that I forwarded after the on-site portion of this QCR, 16 ODs that I identified were substantiated and reported at a single operating position (see highlighted line on the fifth page of attachment 1). Please note that they were not reported by the QCR, and occurred two days prior to the on-site portion of their visit; well within the 45-day period they allege they had reviewed. In general, I find the review to be of a cursory and unsatisfactory nature. Do you note a pattern of poor investigating in the agency offerings to you that obscures the truth, as I do? The expression "garbage in, garbage out comes to my mind.

Other points of interest:

- The QCR, at the top of page three, asserts that the majority of events that they identified during their review were boundary or Letter of Agreement violations. It is important to note that the events they identified seem to be only the handful of random examples that I had provided and that the QCR did not investigate at all the issue of the failure to fulfill the requirement for straight and level flight, now with Director Foushee's Office of Audit and Evaluation, even though they include it as an issue presented to them. The statement at issue minimizes the non-compliance and results from a failure to review all the issues presented to them.
- The review was unable to substantiate the veracity of the years of monthly audits that are required by national directives (and that did not identify a single OE or OD) prior to November, 2008, because the facility did not retain the voice data. They indicate, after reviewing the radar data, that they were interested in 13 events during the prior 12 month period. I find this trivial number to be totally unbelievable. A thorough review of that 12 month period, I am sure, would result in many multiples of that number (more in the range of a several hundred; remember the 16 ODs of one short session, of one position on February 16). Further, the QCR is completely silent as to what the review of the November, December, and January audits revealed. Did it take place? I rarely say I am 100% certain of anything. However, Ms. Gorman, I am 100% certain, given the number of times I was intervening to prevent them, that a competent review of those audits would have revealed many, many unreported OEs / ODs. I had volunteered to participate in those reviews, but was rebuffed. With regard to the failure to retain data, as was required, the QCR attributes it to "confusion over the requirement..." The requirement was clearly written and, the conclusion that the failure was due to confusion takes at face value the word of the managers who were not compliant with regulations, and who had apparently faced administrative actions for previous, serious, inappropriate behaviors. Given my better informed understanding of what exactly was going on at the facility, I can assure you that the failure was not the result of well intentioned, but confused, managers. The recordings were not retained because, as the review accurately suggests, not doing so renders a review of the audits (and their failure to report the OEs / ODs) impossible. This was known to the managers involved, and provided them the level of plausible deniability that has apparently been quite successful.
- The QCR provides substantiation of my allegations with regard to selective enforcement and the culture related to event reporting (see the highlighted portions of the report in attachment two) and was ignored by

the OIG investigation. The OIG investigative report (page 15 of the original report), rather, after quoting my allegation this way:

*The "culture" within the Detroit TRACON "does not allow or support the reporting of air traffic events" and that "[m]anagement officials do not provide the appropriate support or oversight for controllers and do not encourage the reporting of events."*

goes on to say that:

*The evidence does not substantiate the existence of a culture within the Detroit TRACON that does not allow or support the reporting of air traffic events such as operational errors or deviations...*

The QCR is such evidence and it was ignored. Parenthetically, page one of the QCR states that: "NATCA representatives provided letters from twenty-eight D21 employees." I suggest that you request those letters (I wonder if the OIG investigation did so?). They will provide evidence of the culture at the facility as embraced by those air traffic controllers.

I wonder aloud if it was the same Operations Manager that called the Dallas Whistle-blower a "squealer" (Mr. Boland) who the QCR documents as having claimed "there is good cheating, and there is bad cheating..." which, by the way, provides evidence of exceeding the "tacit approval" of a non-reporting culture that the QCR describes.

Although I find much of this QCR unsatisfactory, I won't take your time here to discuss it. I do find noteworthy, however, that the QCR (consequently, the Central Service Center Safety Assurance Group) says, after finding that management has created a poor reporting culture, the following:

*The team believes a shift will take place in the reporting culture as the program [Air Traffic Safety Action Plan] matures and becomes institutionalized.*

The fallacy of ATSAP applied to air traffic control operating quarters is that unlike the environment of the program it was drawn from (the flight deck of a commercial airplane where management oversight does not exist) there **are** managers present that are **supposed** to be monitoring the controller's performance and **intervening** (Crew Resource Management training) **and reporting** as necessary. They are not. Facility management that fails to act with regard for the public trust by tacitly or otherwise contravening reporting requirements will not be corrected by ATSAP. If the suggestion is that managers are not reporting because they are afraid to

report, it is important to note that ATSAP is not applicable to observations made by the watch supervisor.

- Similarly, the QCR also provides anecdotal substantiation of my assertion that Mr. Boland directed me not to investigate possible losses of separation unless they were “ugly,” because the QCR asserts that such was the culture of the facility. It was the culture of the facility because that is the way management wanted it. Please see, again, the highlighted portions of the report in attachment two. The OIG ignored this report when it found “no corroborating documentation. (page 16 of it’s original report)” for my allegation in this regard.
- The QCR unequivocally substantiates my allegation that facility management fostered a passive approach to the investigation of suspected air traffic events (page 17 of the original OIG report). Please see the highlighted portions of the report in attachment three. The OIG, again, ignores this QCR when it states: “We did not find sufficient evidence demonstrating the Operations Manager fostered a passive approach to the reporting of air traffic events.” Exactly what more evidence would they require other than the Operations Managers own words in this regard, reported in the QCR, that ‘there is good cheating and there is bad cheating.’
- The last point I will make in this group of comments, is that the QCR substantiates the facility management’s gross mismanagement when it acknowledges that they were well aware of my longstanding concerns, but did nothing to resolve them. This resulted in the unnecessary perpetuation of thousands of OEs / ODs (I am **not** exaggerating for effect) over the years that I was attempting to correct the non-compliance, and the failure to report same (see the highlighted portions of the QCR in attachment four).

Although unsatisfactory and cursory in itself, this QCR provides evidence that substantiates my allegations and that was ignored by the OIG in their investigation. It is obvious that, intentional or otherwise, the Department of Transportation’s investigation is woefully inadequate, unbelievable and, unreasonable.

Sincerely,



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Timothy M. Funari

- Attachment 1: Detroit TRACON / Tower Facility Tracking Log (printed 03-08-11)
- Attachment 2: Highlighted Portions of the QCR
- Attachment 3: Highlighted Portions of the QCR
- Attachment 4: Highlighted Portions of the QCR

# Attachment 1

## Detroit TRACON / Tower Facility Tracking Log

**Detroit TRACON (D21) Operational Errors/Deviations/Proximity Events on File**

<b>OE/OD Number</b>	<b>Class.</b>	<b>Date</b>	<b>Controller (Dev.)</b>	<b>Destroy Date</b>
<b>2011</b>				
D21-R-11-P-010	PE	02/17/2011		08/17/2013
D21-R-11-P-009	PE	03/05/2011		09/05/2013
D21-R-11-P-008	PE	02/27/2011		08/27/2013
<b>D21-R-11-D-001</b>	<b>OD</b>	<b>02/24/2011</b>		<b>08/24/2013</b>
D21-R-11-P-007	PE	02/23/2011		08/23/2013
D21-R-11-P-006	PE	02/23/2011		08/23/2013
D21-R-11-P-005	PE	01/18/2011		07/18/2013
D21-R-11-P-004	PE	01/27/2011		07/27/2013
<b>D21-R-11-E-007</b>	<b>N/A</b>	<b>01/11/2011</b>		<b>07/11/2013</b>
<b>D21-R-11-E-006</b>	<b>N/A</b>	<b>01/25/2011</b>		<b>07/25/2013</b>
D21-R-11-P-003	PE	01/24/2011		07/24/2013
D21-R-11-P-002	PE	01/22/2011		07/22/2013
<b>D21-R-11-E-005</b>	<b>C</b>	<b>01/19/2011</b>		<b>07/19/2013</b>
<b>D21-R-11-E-004</b>	<b>N/A</b>	<b>01/11/2011</b>		<b>07/11/2013</b>
<b>D21-R-11-E-003</b>	<b>C</b>	<b>01/11/2011</b>		<b>07/11/2013</b>
D21-R-11-P-001	PE	01/06/2011		07/06/2013
<b>D21-R-11-E-002</b>	<b>C</b>	<b>01/06/2011</b>	<b>filed by mistake</b>	<b>07/06/2013</b> <b>Reclass to PE 001</b>
<b>D21-R-11-E-001</b>	<b>C</b>	<b>01/01/2011</b>		<b>07/01/2013</b>
<b>2010</b>				
<b>D21-R-10-E-028</b>	<b>C</b>	<b>12/23/2010</b>		<b>06/23/2013</b>
<b>D21-R-10-E-027</b>	<b>C</b>	<b>12/23/2010</b>		<b>06/23/2013</b>
D21-R-10-P-032	PE	12/12/2010		06/12/2013
<b>D21-R-10-E-026</b>	<b>C</b>	<b>11/30/2010</b>		<b>05/30/2013</b>
D21-R-10-P-031	PE	11/27/2010		05/27/2013
D21-R-10-P-030	PE	11/30/2010		05/30/2013
D21-R-10-P-029	PE	11/30/2010		05/30/2013
<b>D21-R-10-E-025</b>	<b>C</b>	<b>11/22/2010</b>		<b>05/22/2013</b>
D21-R-10-P-028	PE	11/22/2010		05/22/2013
<b>D21-R-10-E-024</b>	<b>C</b>	<b>11/16/2010</b>		<b>05/16/2013</b>
D21-R-10-P-027	PE	11/22/2010		05/22/2013
<b>D21-R-10-D-019</b>	<b>OD</b>	<b>11/20/2010</b>		<b>05/20/2013</b>
<b>D21-R-10-E-023</b>	<b>B</b>	<b>11/17/2010</b>		<b>05/17/2013</b>
D21-R-10-P-026	PE	11/16/2010		05/16/2013
D21-R-10-P-025	PE	11/09/2010		05/09/2013
<b>D21-R-10-D-018</b>	<b>OD</b>	<b>11/05/2010</b>		<b>05/05/2013</b>

<b>D21-R-10-E-022</b>	<b>C</b>	<b>10/29/2010</b>	<b>04/29/2013</b>
<b>D21-R-10-E-021</b>	<b>C</b>	<b>10/29/2010</b>	<b>04/29/2013</b>
D21-R-10-P-024	PE	10/26/2010	04/26/2013
D21-R-10-P-023	PE	10/07/2010	04/07/2013
D21-R-10-P-022	PE	09/28/2010	03/28/2013
D21-R-10-P-021	PE	09/28/2010	03/28/2013
D21-R-10-P-020	PE	10/01/2010	04/01/2013
<b>D21-R-10-E-020</b>	<b>C</b>	<b>09/23/2010</b>	<b>03/23/2013</b>
<b>D21-R-10-E-019</b>	<b>C</b>	<b>09/24/2010</b>	<b>03/24/2013</b>
D21-R-10-P-019	PE	09/21/2010	03/21/2013
D21-R-10-P-018	PE	09/28/2010	03/28/2013
D21-R-10-P-017	PE	09/28/2010	03/28/2013
<b>D21-R-10-D-017</b>	<b>OD</b>	<b>09/10/2010</b>	<b>03/10/2013</b>
<b>D21-R-10-E-018</b>	<b>C</b>	<b>09/13/2010</b>	<b>03/13/2013</b>
<b>D21-R-10-D-016</b>	<b>OD</b>	<b>08/26/2010</b>	<b>02/26/2013</b>
<b>D21-R-10-D-015</b>	<b>OD</b>	<b>08/26/2010</b>	<b>02/26/2013</b>
<b>D21-R-10-E-017</b>	<b>N/A</b>	<b>08/13/2010</b>	<b>02/13/2013</b>
<b>D21-R-10-E-016</b>	<b>C</b>	<b>07/31/2010</b>	<b>01/31/2013</b>
D21-R-10-P-016	PE	07/31/2010	01/31/2013
<b>D21-R-10-D-014</b>	<b>OD</b>	<b>07/04/2010</b>	<b>01/04/2013</b>
D21-R-10-P-015	PE	08/09/2010	02/09/2013
D21-R-10-P-014	PE	08/09/2010	02/09/2013
D21-R-10-P-013	PE	08/03/2010	02/03/2013
<b>D21-R-10-D-013</b>	<b>OD</b>	<b>07/27/2010</b>	<b>01/27/2013</b>
D21-R-10-P-012	PE	07/20/2010	01/20/2013
D21-R-10-P-011	PE	07/19/2010	01/19/2013
D21-R-10-P-010	PE	07/19/2010	01/19/2013
D21-R-10-P-009	PE	07/17/2010	01/17/2013
<b>D21-R-10-E-015</b>	<b>C</b>	<b>07/15/2010</b>	<b>01/15/2013</b>
D21-R-10-P-008	PE	07/12/2010	01/12/2012
<b>D21-R-10-D-012</b>	<b>OD</b>	<b>07/03/2010</b>	<b>01/03/2013</b>
<b>D21-R-10-D-011</b>	<b>OD</b>	<b>07/03/2010</b>	<b>01/03/2013</b>
<b>D21-R-10-E-014</b>	<b>C</b>	<b>06/11/2010</b>	<b>12/11/2012</b>
<b>D21-R-10-E-013</b>	<b>N/A</b>	<b>06/09/2010</b>	<b>12/09/2012</b>
D21-R-10-P-007	PE	06/07/2010	12/07/2012
D21-R-10-P-006	PE	06/02/2010	12/02/2012
<b>D21-R-10-E-012</b>	<b>C</b>	<b>05/11/2010</b>	<b>11/11/2012</b>
<b>D21-R-10-D-010</b>	<b>OD</b>	<b>05/02/2010</b>	<b>11/02/2012</b>
<b>D21-R-10-E-011</b>	<b>B</b>	<b>04/18/2010</b>	<b>10/18/2012</b>
D21-R-10-P-005	PE	04/18/2010	10/18/2012



<b>D21-R-10-E-010 C</b>		<b>04/19/2010</b>	<b>10/19/2012</b>	
D21-R-10-P-004	PE	04/07/2010	10/07/2012	
<b>D21-R-10-E-009 C</b>		<b>03/30/2010</b>	<b>09/30/2012</b>	
<b>D21-R-10-D-005-009</b>		<b>03/26/2010</b>	<b>09/26/2012</b>	
D21-R-10-P-003	PE	03/25/2010	09/25/2012	
<b>D21-R-10-D-004 OD</b>		<b>03/24/2010</b>	<b>09/24/2012</b>	
<b>D21-R-10-D-003 OD</b>		<b>03/24/2010</b>	<b>09/24/2012</b>	
<b>D21-R-10-E-008 C</b>		<b>03/30/2010</b>	<b>09/30/2012</b>	
<b>D21-R-10-E-007 B</b>		<b>03/22/2010</b>	<b>09/22/2012</b>	
D21-R-10-P-002	PE	03/28/2010	09/28/2012	
<del><b>D21-R-10-E-006 N/A</b></del>		<del><b>03/20/2010</b></del>	<del><b>09/20/2012</b></del>	<b>Reclass to non-event</b>
<del><b>D21-R-10-E-005 N/A</b></del>		<del><b>03/20/2010</b></del>	<del><b>09/20/2012</b></del>	<b>Reclass to non-event</b>
<del><b>D21-R-10-E-004 B</b></del>		<del><b>03/20/2010</b></del>	<del><b>09/20/2012</b></del>	
<del><b>D21-R-10-E-003 C</b></del>		<del><b>02/18/2010</b></del>	<del><b>08/18/2012</b></del>	<b>Reclass to Prox Event</b>
<b>D21-R-10-D-002 OD</b>		<b>03/22/2010</b>	<b>09/22/2012</b>	
<b>D21-R-10-E-002 C</b>		<b>03/19/2010</b>	<b>09/19/2012</b>	
<b>D21-R-10-D-001 OD</b>		<b>03/05/2010</b>	<b>09/05/2012</b>	
<b>D21-R-10-E-001 C</b>		<b>01/24/2010</b>	<b>07/24/2012</b>	
D21-R-10-P-001	PE	01/22/2010	07/22/2012	
<b>2009</b>				
<b>D21-R-09-E-040 C</b>		<b>12/15/2009</b>	<b>06/15/2012</b>	
D21-R-09-P-035	PE	12/15/2009	06/15/2012	
<b>D21-R-09-E-039 C</b>		<b>12/09/2009</b>	<b>06/09/2012</b>	
<b>D21-R-09-E-038 C</b>		<b>12/21/2009</b>	<b>06/21/2012</b>	
D21-R-09-P-034	PE	12/19/2009	06/19/2012	
D21-R-09-P-033	PE	12/10/2009	06/10/2012	
<b>D21-R-09-D-046 OD</b>		<b>11/24/2009</b>	<b>05/24/2012</b>	
<b>D21-R-09-D-045 OD</b>		<b>11/24/2009</b>	<b>05/24/2012</b>	
<b>D21-R-09-D-044 OD</b>		<b>11/24/2009</b>	<b>05/24/2012</b>	
<b>D21-R-09-D-043 OD</b>		<b>11/24/2009</b>	<b>05/24/2012</b>	
D21-R-09-P-032	PE	11/23/2009	05/23/2012	
D21-R-09-P-031	PE	12/02/2009	06/02/2012	
<b>D21-R-09-E-037 B</b>		<b>11/24/2009</b>	<b>05/24/2012</b>	
<b>D21-R-09-E-036 C</b>		<b>11/12/2009</b>	<b>05/12/2012</b>	
<b>D21-R-09-E-035 B</b>		<b>11/24/2009</b>	<b>05/24/2012</b>	
<b>D21-R-09-E-034 C</b>		<b>11/21/2009</b>	<b>05/21/2012</b>	
D21-R-09-P-030	PE	11/03/2009	05/03/2012	
D21-R-09-P-029	PE	10/31/2009	04/31/2012	
D21-R-09-P-028	PE	10/24/2009	04/24/2012	
D21-R-09-P-027	PE	10/24/2009	04/24/2012	

D21-R-09-P-026	PE	10/07/2009		04/07/2012	filed by mistake
D21-R-09-P-025	PE	10/07/2009		04/07/2012	
<b>D21-R-09-D-042</b>	<b>OD</b>	<b>10/23/2009</b>		<b>04/23/2012</b>	
<b>D21-R-09-E-033</b>	<b>C</b>	<b>10/22/2009</b>		<b>04/22/2012</b>	
<b>D21-R-09-E-032</b>	<b>N/A</b>	<b>10/06/2009</b>		<b>04/06/2012</b>	
<b>D21-R-09-E-031</b>	<b>C</b>	<b>10/15/2009</b>		<b>04/15/2012</b>	
D21-R-09-P-024	PE	10/09/2009		04/09/2012	
D21-R-09-P-023	PE	10/07/2009		04/07/2012	
<b>D21-R-09-E-030</b>	<b>C</b>	<b>10/06/2009</b>		<b>04/06/2012</b>	
<b>D21-R-09-E-029</b>	<b>see PE #022</b>		<b>reclassified to a PE</b>		<b>filed by mistake</b>
D21-R-09-P-022	PE	10/06/2009		04/06/2012	
<b>D21-R-09-D-041</b>	<b>OD</b>	<b>09/25/2009</b>		<b>03/25/2012</b>	
<b>D21-R-09-D-040</b>	<b>OD</b>	<b>10/02/2009</b>		<b>04/02/2012</b>	
<b>D21-R-09-D-039</b>	<b>OD</b>	<b>10/02/2009</b>		<b>04/02/2012</b>	
<b>D21-R-09-D-038</b>	<b>OD</b>	<b>10/02/2009</b>		<b>04/02/2012</b>	
<b>D21-R-09-E-028</b>	<b>C</b>	<b>09/23/2009</b>		<b>03/23/2012</b>	
<b>D21-R-09-E-027</b>	<b>C</b>	<b>09/11/2009</b>		<b>03/11/2012</b>	<b>should be a PE</b>
<b>D21-R-09-E-026</b>	<b>N/A</b>	<b>09/26/2009</b>		<b>03/26/2012</b>	
<b>D21-R-09-E-025</b>	<b>A</b>	<b>09/24/2009</b>		<b>03/24/2012</b>	<b>TCAS RA w/ a loss?</b>
<b>D21-R-09-E-024</b>	<b>C</b>	<b>09/22/2009</b>		<b>03/22/2009</b>	
<b>D21-R-09-E-023</b>	<b>N/A</b>	<b>09/21/2009</b>		<b>03/21/2009</b>	
<b>D21-R-09-E-022</b>	<b>N/A</b>	<b>09/21/2009</b>		<b>03/21/2012</b>	<b>(DTW error)</b>
D21-R-09-P-021	PE	09/24/2009		03/24/2012	
D21-R-09-P-020	PE	08/26/2009		02/26/2012	
<b>D21-R-09-D-037</b>	<b>OD</b>	<b>09/07/2009</b>		<b>03/07/2012</b>	
D21-R-09-P-019	PE	07/29/2009		01/29/2012	
<del><b>D21-R-09-E-021</b></del>	<del><b>OE</b></del>	<del><b>07/23/2009</b></del>		<del><b>01/23/2012</b></del>	<b>Reclass to non-event</b>
<b>D21-R-09-D-036</b>	<b>OD</b>	<b>07/23/2009</b>		<b>01/23/2012</b>	
D21-R-09-P-018	PE	08/26/2009		02/26/2012	
<b>D21-R-09-E-020</b>	<b>C</b>	<b>08/23/2009</b>		<b>02/23/2012</b>	
<b>D21-R-09-D-035</b>	<b>OD</b>	<b>08/11/2009</b>		<b>02/11/2012</b>	
<b>D21-R-09-E-019</b>	<b>C</b>	<b>08/08/2009</b>		<b>02/08/2012</b>	
D21-R-09-P-017	PE	08/08/2009		02/08/2012	
<b>D21-R-09-D-034</b>	<b>OD</b>	<b>07/25/2009</b>		<b>01/25/2012</b>	
<b>D21-R-09-D-033</b>	<b>OD</b>	<b>07/18/2009</b>		<b>01/18/2012</b>	
<b>D21-R-09-D-032</b>	<b>OD</b>	<b>07/13/2009</b>		<b>01/13/2012</b>	
D21-R-09-P-015	PE	07/02/2009	<i>Proximity Event</i>	01/02/2012	
<b>D21-R-09-E-014</b>	<b>B</b>	<b>06/30/2009</b>		<b>12/30/2011</b>	
<b>D21-R-09-D-031</b>	<b>OD</b>	<b>06/28/2009</b>		<b>12/28/2011</b>	
<b>D21-R-09-D-030</b>	<b>OD</b>	<b>06/25/2009</b>		<b>12/25/2011</b>	

D21-R-09-P-016	PE	06/18/2009		12/18/2011
<b>D21-R-09-E-018</b>	<b>C</b>	<b>06/17/2009</b>		<b>12/17/2009</b>
<b>D21-R-09-E-017</b>	<b>C</b>	<b>06/17/2009</b>		<b>12/17/2009</b>
<b>D21-R-09-E-016</b>	<b>B</b>	<b>06/17/2009</b>		<b>12/17/2011</b>
<b>D21-R-09-E-015</b>	<b>C</b>	<b>06/17/2009</b>		<b>12/17/2011</b>
D21-R-09-P-014	PE	06/17/2009	<i>Proximity Event</i>	12/17/2011
<del>D21-R-09-D-029</del>	<del>OD</del>	<del>06/11/2009</del>		<del>12/11/2011</del> Reclass to non-event
<b>D21-R-09-D-028</b>	<b>OD</b>	<b>06/02/2009</b>		<b>12/02/2011</b>
<b>D21-R-09-E-013</b>	<b>C</b>	<b>05/26/2009</b>		<b>11/26/2011</b>
D21-R-09-P-013	PE	05/16/2009	<i>Proximity Event</i>	11/16/2011
<b>D21-R-09-D-027</b>	<b>OD</b>	<b>05/07/2009</b>		<b>11/07/2011</b>
D21-R-09-P-012	PE	05/03/2009	<i>Proximity Event</i>	11/03/2011
<b>D21-R-09-E-012</b>	<b>C</b>	<b>04/28/2009</b>		<b>10/28/2011</b>
<b>D21-R-09-E-011</b>	<b>C</b>	<b>04/24/2009</b>		<b>10/24/2011</b>
<b>D21-R-09-E-009</b>	<b>C</b>	<b>04/20/2009</b>		<b>10/20/2011</b>
<b>D21-R-09-E-010</b>	<b>C</b>	<b>04/17/2009</b>		<b>10/17/2011</b>
<b>D21-R-09-D-021</b>	<b>OD</b>	<b>04/17/2009</b>		<b>10/17/2011</b> OD's 021-026
<b>D21-R-09-E-008</b>	<b>THIS REPORT SHOULD BE A PE</b>			
D21-R-09-P-011	PE	04/17/2009	<i>Proximity Event</i>	10/17/2011
<b>D21-R-09-E-007</b>	<b>B</b>	<b>04/17/2009</b>		<b>10/17/2011</b>
<b>D21-R-09-E-006</b>	<b>B</b>	<b>04/17/2009</b>		<b>10/17/2011</b>
<b>D21-R-09-D-020</b>	<b>THIS REPORT SHOULD BE A PD-Reclassified to a PD</b>			
<b>D21-R-09-E-005</b>	<b>C</b>	<b>04/13/2009</b>		<b>10/13/2011</b>
<b>D21-R-09-D-019</b>	<b>OD</b>	<b>04/13/2009</b>		<b>10/13/2011</b>
<b>D21-R-09-E-004</b>	<b>C</b>	<b>04/07/2009</b>		<b>10/07/2011</b>
<b>D21-R-09-E-003</b>	<b>C</b>	<b>04/07/2009</b>		<b>10/07/2011</b>
<b>D21-R-09-D-018</b>	<b>OD</b>	<b>03/26/2009</b>		<b>09/26/2011</b>
D21-R-09-P-010	PE	03/25/2009	<i>Proximity Event</i>	09/25/2011
D21-R-09-P-009	PE	03/25/2009	<i>Proximity Event</i>	09/25/2011
D21-R-09-P-007	PE	03/19/2009	<i>Proximity Event</i>	09/19/2011
<b>D21-R-09-D-001</b>	<b>OD</b>	<b>03/11/2009</b>		<b>09/11/2011</b>
D21-R-09-P-008	PE	03/10/2009	<i>Proximity Event</i>	09/10/2011
<b>D21-R-09-E-002</b>	<b>C</b>	<b>03/10/2009</b>		<b>09/10/2011</b>
D21-R-09-P-006	PE	03/10/2009	<i>Proximity Event</i>	09/10/2011
D21-R-09-P-005	PE	03/08/2009	<i>Proximity Event</i>	09/08/2011
D21-R-09-P-004	PE	02/27/2009	<i>Proximity Event</i>	08/27/2011
<del>D21-R-09-E-001</del>	<del>B (W)</del>	<del>02/22/2009</del>		<del>08/22/2011</del> Reclass to non-event
D21-R-09-P-003	PE	02/19/2009	<i>Proximity Event</i>	08/19/2011
<b>D21-R-09-D-002</b>	<b>OD</b>	<b>02/16/2009</b>		<b>08/16/2011</b> OD's 002-017
D21-R-09-P-002	PE	02/09/2009	<i>Proximity Event</i>	08/09/2011

D21-R-09-P-001	PE	01/14/2009	<i>Proximity Event</i>	07/14/2011
<b>2008</b>				
D21-R-08-D-004	OD	11/30/2008		05/30/2011
D21-R-08-E-013	C	11/10/2008		05/10/2011
D21-R-08-D-003	OD	10/30/2008		04/30/2011
D21-R-08-D-002	OD	09/20/2008		03/20/2011
D21-R-08-E-012	C	09/10/2008		03/10/2011
D21-R-08-P-005	PE	09/04/2008	<i>Proximity Event</i>	03/04/2011
D21-R-08-P-007	PE	09/03/2008	<i>Proximity Event</i>	03/03/2011

**Detroit Metro Tower (DTW) Operational Errors/Deviations/Proximity Events on File**

<b><u>OE/OD Number</u></b>	<b><u>Class.</u></b>	<b><u>Date</u></b>	<b><u>Controller (Dev.)</u></b>	<b><u>Destroy Date</u></b>
<b><u>2011</u></b>				
DTW-T-11-D-002	OD	01/26/2011		07/26/2013
DTW-T-11-D-001	OD	01/10/2011		07/10/2013
<b><u>2010</u></b>				

<b>2010-T-10-D-016 OD</b>	<b>12/08/2010</b>	<b>06/08/2013</b>
<b>DTW-T-10-E-005 B</b>	<b>11/24/2010</b>	<b>05/24/2013</b>
<b>DTW-T-10-D-015 OD</b>	<b>10/07/2010</b>	<b>04/07/2013</b>
<b>DTW-T-10-D-014 OD</b>	<b>09/06/2010</b>	<b>03/06/2013</b>
<b>DTW-T-10-P-002 PE</b>	<b>08/21/2010</b>	<b>02/21/2013</b>
<b>DTW-T-10-E-004 RI</b>	<b>08/14/2010</b>	<b>02/14/2013</b>
<b>DTW-T-10-E-003 B</b>	<b>08/22/2010</b>	<b>02/22/2013</b>
<b>DTW-T-10-D-013 OD</b>	<b>07/21/2010</b>	<b>01/21/2013</b>
<b>DTW-T-10-P-001 PE</b>	<b>07/21/2010</b>	<b>01/21/2013</b>
<b>DTW-T-10-D-012 OD</b>	<b>06/30/2010</b>	<b>12/30/2012</b>
<b>DTW-T-10-D-011 OD</b>	<b>06/25/2010</b>	<b>12/25/2012</b>
<b>DTW-T-10-D-010 OD</b>	<b>06/15/2010</b>	<b>12/15/2012</b>
<b>DTW-T-10-D-009 OD</b>	<b>06/14/2010</b>	<b>12/14/2012</b>
<b>DTW-T-10-D-008 OD</b>	<b>05/07/2010</b>	<b>11/07/2012</b>
<b>DTW-T-10-D-007 OD</b>	<b>05/04/2010</b>	<b>11/04/2012</b>
<b>DTW-T-10-D-006 OD</b>	<b>04/13/2010</b>	<b>10/13/2012</b>
<b>DTW-T-10-D-005 OD</b>	<b>03/11/2010</b>	<b>09/11/2012</b>
<del><b>DTW-T-10-D-004 OD</b></del>	<del><b>02/18/2010</b></del>	<del><b>08/22/2012</b></del>
<b>DTW-T-10-E-002 RI</b>	<b>02/16/2010</b>	<b>08/16/2012</b>
<b>DTW-T-10-D-003 OD</b>	<b>02/11/2010</b>	<b>08/11/2012</b>
<b>DTW-T-10-D-002 OD</b>	<b>02/10/2010</b>	<b>08/10/2012</b>
<b>DTW-T-10-E-001 C</b>	<b>02/09/2010</b>	<b>08/09/2012</b>
<b>DTW-T-10-D-001 OD</b>	<b>01/28/2010</b>	<b>07/28/2012</b>
<b>2009</b>		
<b>DTW-T-09-D-035 OD</b>	<b>12/30/2009</b>	<b>06/30/2012</b>
<b>DTW-T-09-E-005 C</b>	<b>12/25/2009</b>	<b>06/25/2012</b>
<b>DTW-T-09-E-004 A</b>	<b>12/25/2009</b>	<b>06/25/2012</b>
<b>DTW-T-09-D-034 OD</b>	<b>11/24/2009</b>	<b>05/24/2012</b>
<b>DTW-T-09-E-003 RI</b>	<b>12/04/2009</b>	<b>06/04/2012</b>
<b>DTW-T-09-D-033 OD</b>	<b>11/24/2009</b>	<b>05/24/2012</b>
<b>DTW-T-09-D-032 OD</b>	<b>10/30/2009</b>	<b>04/30/2012</b>
<b>DTW-T-09-D-031 OD</b>	<b>09/27/2009</b>	<b>03/27/2012</b>
<b>DTW-T-09-D-030 OD</b>	<b>09/20/2009</b>	<b>03/20/2012</b>
<b>DTW-T-09-D-029 OD</b>	<b>09/07/2009</b>	<b>03/07/2012</b>
<b>DTW-T-09-D-028 OD</b>	<b>09/08/2009</b>	<b>03/08/2012</b>
<b>DTW-T-09-D-027 OD</b>	<b>09/01/2009</b>	<b>03/01/2012</b>
<b>DTW-T-09-D-026 OD</b>	<b>09/11/2009</b>	<b>03/11/2012</b>
<b>DTW-T-09-D-025 OD</b>	<b>08/30/2009</b>	<b>02/30/2012</b>
<b>DTW-T-09-D-024 OD</b>	<b>09/20/2009</b>	<b>03/20/2012</b>
<b>DTW-T-09-D-023 OD</b>	<b>08/21/2009</b>	<b>02/21/2012</b>

Reclass to ZOB PD

<u>DTW-T-09-E-002 B</u>	<u>08/08/2009</u>		<u>02/08/2012</u>
<u>DTW-T-09-D-022 OD</u>	<u>07/09/2009</u>	<i>Procedural</i>	<u>01/09/2012</u>
<u>DTW-T-09-D-021 OD</u>	<u>06/28/2009</u>	[REDACTED] (D21)	<u>12/28/2011</u> filed DTW by mistake
<u>DTW-T-09-D-020 OD</u>	<u>06/16/2009</u>	[REDACTED]	<u>12-16-2011</u>
<u>DTW-T-09-D-019 OD</u>	<u>06/15/2009</u>	[REDACTED]	<u>12/15/2011</u>
<u>DTW-T-09-D-018 OD</u>	<u>06/11/2009</u>	[REDACTED]	<u>12/11/2011</u>
<u>DTW-T-09-D-017 OD</u>	<u>06/11/2009</u>	[REDACTED]	<u>12/11/2011</u>
<u>DTW-T-09-D-016 OD</u>	<u>06/06/2009</u>	(Primary) [REDACTED]	<u>12/06/2011</u>
<u>DTW-T-09-D-015 OD</u>	<u>05/22/2009</u>	[REDACTED]	<u>11/22/2011</u>
<u>DTW-T-09-D-014 OD</u>	<u>05/02/2009</u>	[REDACTED]	<u>11/02/2011</u>
<u>DTW-T-09-D-013 OD</u>	<u>05/02/2009</u>	[REDACTED]	<u>11/02/2011</u>
<u>DTW-T-09-D-012 OD</u>	<u>05/11/2009</u>	[REDACTED]	<u>11/11/2011</u>
<u>DTW-T-09-D-011 OD</u>	<u>05/01/2009</u>	[REDACTED]	<u>11/01/2011</u>
<u>DTW-T-09-D-010 OD</u>	<b>THIS REPORT WAS ENTERED BY MISTAKE</b>		
<u>DTW-T-09-D-009 OD</u>	<u>04/13/2009</u>	[REDACTED]	<u>10/13/2011</u>
<u>DTW-T-09-D-008 OD</u>	<u>04/03/2009</u>	[REDACTED]	<u>10/03/2011</u>
<u>DTW-T-09-D-007 OD</u>	<u>03/31/2009</u>	[REDACTED]	<u>09/31/2011</u>
<u>DTW-T-09-E-001 C</u>	<u>03/08/2009</u>	[REDACTED]	<u>09/08/2011</u>
<u>DTW-T-09-D-006 OD</u>	<u>03/19/2009</u>	[REDACTED]	<u>09/19/2011</u>
<u>DTW-T-09-D-005 OD</u>	<u>03/06/2009</u>	<i>Procedural</i>	<u>09/06/2011</u>
<u>DTW-T-09-D-004 OD</u>	<u>02/12/2009</u>	[REDACTED]	<u>08/12/2011</u>
<u>DTW-T-09-D-003 OD</u>	<u>02/12/2009</u>	[REDACTED]	<u>08/12/2011</u>
<u>DTW-T-09-D-002 OD</u>	<u>02/02/2009</u>	[REDACTED]	<u>08/02/2011</u>
<u>DTW-T-09-D-001 OD</u>	<u>01/02/2009</u>	[REDACTED]	<u>07/02/2011</u>
<b>2008</b>			
<u>DTW-T-08-D-007 OD</u>	<u>11/20/2008</u>	[REDACTED]	<u>05/20/2011</u>
<u>DTW-T-08-D-006 OD</u>	<u>10/12/1008</u>	[REDACTED]	<u>04/12/2011</u>
<u>DTW-T-08-E-006 B</u>	<u>08/31/2008</u>	[REDACTED]	<u>02/03/2011</u>
<u>DTW-T-08-D-005 OD</u>	<u>08/16/2008</u>	[REDACTED]	<u>02/16/2011</u>
<u>DTW-T-08-E-005 B</u>	<u>08/14/2008</u>	[REDACTED]	<u>02/14/2011</u>
<u>DTW-T-08-D-004 OD</u>	<u>08/07/2008</u>	[REDACTED]	<u>02/07/2011</u>
<u>DTW-T-08-D-003 OD</u>	<u>08/06/2008</u>	[REDACTED]	<u>02/06/2011</u>

## Attachment 2

### Highlighted Portions of QCR

data for ATO-S Random Facility Audits conducted was also reviewed. It should be noted, voice data for the Random Audits conducted by the facility prior to November 2008 was not available due to confusion about the requirement to retain the voice data with the radar data.

Letters of Agreements between D21 and four satellite airports were reviewed: Pontiac (PIK), Ann Arbor (ARB), Willow Run (YIP), and Troy Oakland (VLL). The relationship between traffic patterns for these airports and D21's sector boundaries was reviewed.

On February 20, 2009, an additional issue was given to the team lead while at the facility. A question was raised about accuracy of the average Runway Occupancy Time (ROT), as calculated in FY-2008, for Runway 4R/22L. Both the Director and ATM were advised of the new issue and it was included for the QCR team to review.

## **SUMMARY AND FINDINGS**

On February 18-20, 2009, the CSC SAG Operations Evaluation Team conducted the on-site phase of the investigation to gather and analyze pertinent information. The team consisted of Dorothy Davis, Team Lead, SAG Operations Evaluation Team Manager; Jim Kroger, Quality Assurance Manager, O'Hare Airport Traffic Control Tower; John Crawford, SAG Operations Evaluation Team; and David Ayars, SAG Operations Evaluation Team.

During the review the team looked at five issues: Safety culture around event reporting, Effectiveness of Safety Assurance Program Oversight, Compliance with Standard Operating Procedures and Letter of Agreement Requirements, Adequacy of D21's Airspace Design, and Validation of Runway Occupancy Time for Runway 4R/22L.

An in-brief was conducted to introduce members of the team to the facility's top management officials and explain the QCR process and protocol for interface with facility personnel. The facility provided an overview of D21's airspace design and explained traffic flows. The allegations were shared and there was acknowledgment of familiarity with the issues by the manager present. The QCR team then requested and was afforded the opportunity to observe the TRACON operation. Out-briefs were provided daily to the ATM on findings and observations.

### **I. Safety Culture around Event Reporting**

The allegations contained dates and times for multiple events that occurred between January 25, 2009 and February 10, 2009. The information was given to the facility for review. The facility filed 3 operational errors and 11 operational deviations.

Based on information obtained during interviews, it appears there are misperceptions among CPCs what constitutes an event that should be reported. It was shared by CPC's, "If an event is not that serious then it doesn't need to be reported." To illustrate the point the following example was offered: "An aircraft climbed four hundred feet above the assigned altitude. There was no loss of separation, so it wasn't that bad." Another comment was "Getting pilots in trouble for a minor infraction isn't good customer service or being a good team player." It appears norms and misperceptions exist around "the seriousness of an event" being used as a determining factor in decisions made about what events, including pilot deviations, to report.



The majority of the events identified during our review involve boundary or letter of agreement violations. Considerable discussion took place with interviewees about these events and rules involved. It was shared several times how difficult it is for controllers to tell if aircraft are less than 1.5 NM from the boundary. As it was stated by an OM, "There is good cheating and there is bad cheating..." appears to reflect cultural norms around event reporting. The team does not believe the reporting culture has been created by controllers. It appears management has given its tacit approval of the operations as observed.

In December 2008, the facility was covered under the Air Traffic Safety Action Program (ATSAP). The team believes a shift will take place in the reporting culture at D21 as the program matures and becomes institutionalized.

## II. Quality Assurance Program Oversight

The facility's Safety Assurance Program directive, DTW7210.56A as written, appears to be in compliance with ATO Requirements for content. However, the facility does not appear to be in compliance with FAA Order 7210.56, Air Traffic Quality Assurance requirements for the handling, processing, tracking and follow-up on Quality Assurance Reviews (QAR) and Random Monthly Audits. Inconsistencies were found in the facility's daily logs, local QAR Forms, and data contained in the facility's QAR Tracking System.

For the ATC system to be effective, it is essential that all system deficiencies be identified and corrected. Serious system deficiencies may be involved in air traffic incidents that fall outside of the definitions and corrective procedures for OE/OD's. QAR provide an opportunity for the identification, investigation, and resolution through corrective training of such deficiencies.

**A. QAR Logging:** The team reviewed D21's FAA Form 7230-4, Daily Logs, for the 45-days beginning December 28, 2008 thru February 10, 2009. The logs contained 55 "Q" entries. It was unclear in many instances what, if any, actions were taken to investigate events. Numerous items indicated "QAR Initiated" followed shortly afterwards by "QAR Concluded". At times, "ATC services normal or routine with no performance deficiencies" was included. It appeared "personal observation" of controller performance by OMIC's, FLMIC's, or CIC's was the sole method used to investigate events. It was also unclear if a follow-up review was conducted by the QA office.

**B. QAR Local Form and Follow-up:** The 55 "Q" entries shown on the daily logs only contained 5 events that were documented using the facility's Quality Assurance Review Form, DTW7210-6 (Appendix 2). The criterion for the OM's/FLM's/CJC's decision to use the form is unclear. The form did not contain instructions that cover how it should be completed. The forms reviewed were not always complete or did not clearly capture the facts involved.

As an example a QAR contained the following Event Summary and Conclusion.

**Event Summary:** "TCAS RA-Loss of separation @ 1543Z. After reviewing the replay targets didn't merge. However, from my observations of the situation and the replay, the controller either didn't think MES was a factor or she didn't see the 6,000 inbound. After a discussion with the employee, she didn't see MES @ 6,000 until separation became an issue. She then took action to help mitigate the circumstances. No further action taken."

## Attachment 3

### Highlighted Portions of QCR

The majority of the events identified during our review involve boundary or letter of agreement violations. Considerable discussion took place with interviewees about these events and rules involved. It was shared several times how difficult it is for controllers to tell if aircraft are less than 1.5 NM from the boundary. As it was stated by an OM, "There is good cheating and there is bad cheating..." appears to reflect cultural norms around event reporting. The team does not believe the reporting culture has been created by controllers. It appears management has given its tacit approval of the operations as observed.

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**B. QAR Local Form and Follow-up:** The 55 "Q" entries shown on the daily logs only contained 5 events that were documented using the facility's Quality Assurance Review Form, DTW7210-6 (Appendix 2). The criterion for the OM's/FLM's/CJC's decision to use the form is unclear. The form did not contain instructions that cover how it should be completed. The forms reviewed were not always complete or did not clearly capture the facts involved.

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## Attachment 4

### Highlighted Portions of QCR

**Detroit Metro TRACON Quality Control Review Report**  
Central Service Center, Safety Assurance Group, Operations Evaluation Team  
February 10-20, 2009

## **INTRODUCTION**

On February 10, 2009, at the request of the Central Service Area's (CSA) Director Terminal Operations, the Safety Assurance Group (SAG) initiated a Quality Control Review (QCR) of the Detroit Metro TRACON (D21) operation. The review is in response to allegations raised by a member of D21's management team. The issues raised cover a period as far back as 2002 and relate to operational safety being compromised. The QCR has been conducted to assess the validity of the operational safety issues raised.

ATO Terminal Operations were notified of the initiation of the review by the CSA Terminal Director of Operations. ATO Safety authorized events identified during the review to be reported as system events, i.e. AIS-(R)-(H)-09-E/D/P-XXX. The facility is covered under FAC 7210.669, Air Traffic Safety Action Program (ATSAP); therefore, events identified will be processed accordingly.

## **SCOPE**

The CSA SAG Quality Control Review assessed the following at Detroit Metro TRACON:

- Safety Culture around event reporting
- Effectiveness of Quality Assurance Program Oversight
- Compliance with Standard Operating Procedures (SOP) and Letters of Agreement (LOA) Requirements
- Adequacy of D21's Airspace Design
- Validation of Runway Occupancy Time for Runway 4R/22L

## **METHODOLOGY**

On February 18-20, 2009, the CSC SAG Operations Evaluation Team conducted an on-site visit to gather information and review data. The air traffic manager, quality assurance manager, 2 operations managers, 1 front-line manager (FLM), 1 certified professional controller (CPC) and 2 NATCA representatives were interviewed. The NATCA representatives, FLM and CPC requested to meet with the team. The NATCA representatives provided letters from twenty-eight D21 employees. The majority of these individuals are current employees, but some are retired.

The team reviewed D21's Safety Assurance Order, Standard Operating Procedures and other local documents. Availability of radar and voice data for specific events identified in the allegations was limited due to agency document and data retention requirements. However, a review was conducted of radar and voice data from the 45 days prior to the team's visit. Radar

data for ATO-S Random Facility Audits conducted was also reviewed. It should be noted, voice data for the Random Audits conducted by the facility prior to November 2008 was not available due to confusion about the requirement to retain the voice data with the radar data.

Letters of Agreements between D21 and four satellite airports were reviewed: Pontiac (PIK), Ann Arbor (ARB), Willow Run (YIP), and Troy Oakland (VLL). The relationship between traffic patterns for these airports and D21's sector boundaries was reviewed.

On February 20, 2009, an additional issue was given to the team lead while at the facility. A question was raised about accuracy of the average Runway Occupancy Time (ROT), as calculated in FY-2008, for Runway 4R/22L. Both the Director and ATM were advised of the new issue and it was included for the QCR team to review.

## **SUMMARY AND FINDINGS**

On February 18-20, 2009, the CSC SAG Operations Evaluation Team conducted the on-site phase of the investigation to gather and analyze pertinent information. The team consisted of Dorothy Davis, Team Lead, SAG Operations Evaluation Team Manager; Jim Krieger, Quality Assurance Manager, O'Hare Airport Traffic Control Tower; John Crawford, SAG Operations Evaluation Team; and David Ayars, SAG Operations Evaluation Team.

During the review the team looked at five issues: Safety culture around event reporting, Effectiveness of Safety Assurance Program Oversight, Compliance with Standard Operating Procedures and Letter of Agreement Requirements, Adequacy of D21's Airspace Design, and Validation of Runway Occupancy Time for Runway 4R/22L.

An in-brief was conducted to introduce members of the team to the facility's top management officials and explain the QCR process and protocol for interface with facility personnel. The facility provided an overview of D21's airspace design and explained traffic flows. The allegations were shared and there was acknowledgment of familiarity with the issues by the manager present. The QCR team then requested and was afforded the opportunity to observe the TRACON operation. Out-briefs were provided daily to the ATM on findings and observations.

### **I. Safety Culture around Event Reporting**

The allegations contained dates and times for multiple events that occurred between January 25, 2009 and February 10, 2009. The information was given to the facility for review. The facility filed 3 operational errors and 11 operational deviations.

Based on information obtained during interviews, it appears there are misperceptions among CPCs what constitutes an event that should be reported. It was shared by CPC's, "If an event is not that serious then it doesn't need to be reported." To illustrate the point the following example was offered: "An aircraft climbed four hundred feet above the assigned altitude. There was no loss of separation, so it wasn't that bad." Another comment was "Getting pilots in trouble for a minor infraction isn't good customer service or being a good team player." It appears norms and misperceptions exist around "the seriousness of an event" being used as a determining factor in decisions made about what events, including pilot deviations, to report.

The majority of the events identified during our review involve boundary or letter of agreement violations. Considerable discussion took place with interviewees about these events and rules involved. It was shared several times how difficult it is for controllers to tell if aircraft are less than 1.5 NM from the boundary. As it was stated by an OM, "There is good cheating and there is bad cheating..." appears to reflect cultural norms around event reporting. The team does not believe the reporting culture has been created by controllers. It appears management has given its tacit approval of the operations as observed.

In December 2008, the facility was covered under the Air Traffic Safety Action Program (ATSAP). The team believes a shift will take place in the reporting culture at D21 as the program matures and becomes institutionalized.

## II. Quality Assurance Program Oversight

The facility's Safety Assurance Program directive, DTW7210.56A as written, appears to be in compliance with ATO Requirements for content. However, the facility does not appear to be in compliance with FAA Order 7210.56, Air Traffic Quality Assurance requirements for the handling, processing, tracking and follow-up on Quality Assurance Reviews (QAR) and Random Monthly Audits. Inconsistencies were found in the facility's daily logs, local QAR Forms, and data contained in the facility's QAR Tracking System.

For the ATC system to be effective, it is essential that all system deficiencies be identified and corrected. Serious system deficiencies may be involved in air traffic incidents that fall outside of the definitions and corrective procedures for OE/OD's. QAR provide an opportunity for the identification, investigation, and resolution through corrective training of such deficiencies.

**A. QAR Logging:** The team reviewed D21's FAA Form 7230-4, Daily Logs, for the 45-days beginning December 28, 2008 thru February 10, 2009. The logs contained 55 "Q" entries. It was unclear in many instances what, if any, actions were taken to investigate events. Numerous items indicated "QAR initiated" followed shortly afterwards by "QAR Concluded". At times, "ATC services normal or routine with no performance deficiencies" was included. It appeared "personal observation" of controller performance by OMIC's, FLMIC's, or CIC's was the sole method used to investigate events. It was also unclear if a follow-up review was conducted by the QA office.

**B. QAR Local Form and Follow-up:** The 55 "Q" entries shown on the daily logs only contained 5 events that were documented using the facility's Quality Assurance Review Form, DTW7210-6 (Appendix 2). The criterion for the OM's/FLM's/CIC's decision to use the form is unclear. The form did not contain instructions that cover how it should be completed. The forms reviewed were not always complete or did not clearly capture the facts involved.

As an example a QAR contained the following Event Summary and Conclusion.

**Event Summary:** "TCAS RA-Loss of separation @ 1543Z. After reviewing the replay targets didn't merge. However, from my observations of the situation and the replay, the controller either didn't think MES was a factor or she didn't see the 6,000 inbound. After a discussion with the employee, she didn't see MES @ 6,000 until separation became an issue. She then took action to help mitigate the circumstances. No further action taken."

**Conclusion:** *"No Controller deficiencies identified."*

The document did not contain an aircraft call-sign or type, event description, reason for the TCAS RA- Loss of separation, or information about the closest proximity. There was also no controller action or any other facts provided about the event. It was noted that an FAA Form 8020-11, Incident Report, was completed for the event. However, there was no indication on the QAR or facility's FAA Form 7210-4 of the action.

**C. QAR Tracking & Trend Analysis:** D21's Safety Assurance Program directive states, "The Quality Assurance Department will assist as needed and track the QAR's and supporting documentation. The facility's QAR Tracking Log for January 1, 2009 thru February 22, 2009, was reviewed. The report contained 60 events for the time period. It showed 1 Proximity Event being filed; however, ATO-S was unable to locate a copy. Of the 60 events, there were 10 that were captured on a QAR Form. Only two of the forms noted controller deficiencies. In fact, "Not related to the incident" was noted on one of the forms in the section for deficiencies.

Of the 60 events logged, 49 events indicated "Personal Observation" was the method of investigation. It was not clear what analysis or follow-up was conducted by the QA Department for the events. A request was made for a copy of the Technical Training Report that should be prepared for the ATM covering training assigned through the Technical Training Discussion process, but was not provided.

**D. Random Monthly Audits:** The team reviewed radar data retained in conjunction with the prior 12 months' Random Audits. The team requested voice data associated with 13 operations that occurred prior to November 2008. The voice data had not been retained. Therefore, it could not be determined if requirements were met for the 13 operations.

One of the events appeared to involve application of visual separation between two aircraft. The other events, involved application for visual approaches while on a South Flow Configuration. It appeared aircraft were being turned on to the final approach course well inside 4.0 NM of the runway. The D21/DTW Letter of Agreement requires the early turn on to be coordinated with the tower.

It should be noted, in November 2008 AJS identified facilities were not saving voice data with the radar data reviewed for Monthly Random Audits. The facility now saves both radar and voice data for Random Monthly Audits.

### **III. Standard Operating Procedures (SOP) and Letter of Agreement (LOA) Requirements**

It appears that D21's SOP does not consistently comply with requirements set forth in FAA Order 7110.65, Air Traffic Control, and FAA Order 7210.3, Facility Operations and Administration.

**A. SOP Requirements:** The facility's SOP contains 29 Pre-arranged Coordination Procedures (PACP). Radar data for several days when D21 was operating on the North Flow Configuration was reviewed. Numerous departure aircraft were observed not meeting at or above altitude restrictions associated with PACP. Aircraft were also observed in the departure corridors, but less than 1.5 NM from sector boundaries.



Voice data was reviewed, but did not contain coordination for point-outs on the traffic. There may have been an agreement between controllers "to watch and miss" each other's traffic. However, the voice data also did not contain such coordination or was unavailable.

**B. LOA Requirements:** 11 operational deviations were reported during this QCR. Several events involved aircraft being vectored to the final approach course within 4 NM of the airport. The DTW/D21 LOA establishes the requirement. Correct application of the requirement has been debated in the facility for years. Clearly opposing views exist about the meaning and intent. Yet, no action has been taken to obtain an official interpretation from ATOT, or remove the requirement from the LOA.

A second set of issues involve satellite airport operations. One involves requirement for missed approach procedures at Troy Airport (VLL). The published approach and missed approach procedure are both off of the Pontiac VOR (PTK). Two questions were raised. "Does the missed approach for VLL conflict with the operation at PTK airport?" And, "What needs to be protected if a missed approach is executed at VLL?" There appears to be a long standing debate in the facility about whether an alternate missed approach procedure is required to be published in order to be issued. However, no action appears to have been taken to obtain clarification or interpretations.

The individual raising the allegations that are herein being reviewed has cited additional issues. The facility appears to have had open debate about them, but has not obtained clarifications or interpretations from the appropriate office. The full list is attached and will be given to the CSC Operations Support Group for follow-up with the facility.

#### IV. Adequacy of D21's Airspace Design

D21's Airspace does not appear to be designed to ensure movement of traffic flows in, out, and through the Detroit Metro Airspace without controllers being burden with completing additional coordination with each other. The proximity of traffic flows to sector boundaries appears to routinely require controllers to make multiple point-outs or enter into "special agreements" with each other to ensure compliance with FAA Order 7110.65, Coordination of use of airspace requirements.

Again, the facility has at least 29 PACP in place to mitigate coordination associated with point-outs for established traffic flows. Individuals interviewed indicate changes are in progress that involves adding an additional PACP.

#### V. Validation of Runway Occupancy Time for 4R/22L

On February 24, 2009, the team requested a copy of the documentation for D21's FY-2008 4R/22L Runway Occupancy Time (ROT) documentation. On March 3, 2009, after completing an extensive search, the facility advised the documentation could not be found.

The air traffic manager took immediate action to suspend the use of the reduced separation requirement for the 4R/22L. Operation. The operation will remain suspended until an average 4R/22L ROT is validated based on new data. The D21 traffic management officer is gathering data to complete the validation process.



## Federal Aviation Administration

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### Memorandum

Date:

To: Nancy B. Kort, Director Terminal Operations, Central Terminal Service Area  
From: David P. Medina, Group Manager, Central Service Area  
Prepared by: Dorothy M. Davis, Team Manager, Central Service Area  
Subject: Detroit Metro TRACON Quality Control Review Team Report

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As per your request, the Central Service Area (CSA) Safety Assurance Group Operational Evaluation Team has completed a Quality Control Review (QCR) of the operation at Detroit Metro TRACON (D21). The review is in response to allegations raised by an employee at D21. The employee alleged that operational safety is being comprised at the facility. The QCR Team's report is attached.

On February 20, 2009, the District Manager was verbally briefed during an out brief by the team. Since that time several actions have been initiated by the District Manager to address many, if not all, of the issues identified in the report.

If you have any questions, or would like additional information, please contact Dorothy M. Davis, Team Manager CSA Operational Evaluation Team (817) 222-5553.