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85032 Sagaponack Drive
Fernandina Beach, FL 32034

Mr. William Reukauf
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036

Re: OSC File Nos. D1-07-2471 and D1-08-1015

03 February, 2010

Dear Mr. Reukauf,

I am writing in response to the report submitted by the Honorable Secretary of Transportation regarding the above referenced OSC files concerning matters at Memphis International Airport Air Traffic Control Tower. This report represents two separately submitted complaints combined into one for investigatory purposes. Having worked at Memphis ATCT for eight years, I have direct knowledge and experience with the issues contained in the report so I am providing comment whether the allegation was contained in my specific disclosure or not, as warranted.

I wish to make it known at the outset that I find the agency report seriously deficient or misleading despite whole or partial substantiation on 8 of the 9 allegations submitted. This is deeply troubling.

In addition to the specific allegations made and answered, the report also included a section regarding operational error reporting and investigation. Portions of this are also of great concern to me. I have included comments for that as well.

In order to avoid the need to jump between my responses and the report, I have included a summary of the specific allegations and the agency response prior to my comments for that specific allegation.

Allegation 1: Runway 27 arrivals executing a go-around or missed approach could come into conflict with traffic landing Runway 18R.

This allegation was partially substantiated.

The agency did not specifically address the true crux of my concern. A "late stage" go around, either immediately over the runway or after touchdown for whatever reason, simply **DOES NOT** afford controllers or flight crews "sufficient time" to ensure the safety of either the aircraft landing runway 18R nor the aircraft attempting to obtain altitude off runway 27. (Attachment 1) In fact, this exact scenario occurred as recently as December 22, 2010 (Attachment 2, FDX1210) In that event, the go-around traffic

conflicted with traffic landing runway 18R. While that event had a –thankfully - favorable (zero fatality) outcome, I steadfastly believe it is very misleading to characterize any operation involving large aircraft that have to go around when already over runway 27 as capable of doing much more than struggling to obtain altitude for the first mile of the operation. These aircraft would be in a full “dirty” configuration for landing, especially in warmer temperature conditions when climb performance is most affected. In such an incident, just getting the aircraft back in the air is no simple task, getting airborne and turning a 150-foot long jet - full of passengers - immediately to avert a conflict within 700 feet of the departure end of the runway borders on denying the very physics of flight. In fact, given the typical rate of turn of large jet aircraft, it would be more reasonable to assume attempting such a turn would actually increase the duration of the conflict and the amount of surface area a conflicting aircraft would be exposed to collide with. More importantly, the claim of infrequency as rationale for allowing this type of event simply does not provide ample justification for allowing it to happen - when it happens the worst possible outcome is *death*, not a “near-collision” as the report would imply. One is too many. This operation amounts to playing Russian roulette with air carrier aircraft. That is simply unacceptable. Attachment 3 documents yet another CRDA related go-around. (Attachment 3)

The agency finding that the distance of 1.82 miles from the flight path of traffic landing runway 18R and the landing threshold of runway 27 as being sufficient to allow controllers time to direct traffic landing runway 27 away from 18R arrivals **COMPLETELY IGNORES** the scenario I put forth above. In fact, based on a conservative estimate of the airspeed a large passenger jet aircraft executing a late stage go-around would require to get airborne (approximately 140 knots – nearly 14,200 feet per minute) and a conservative potential lift-off point in summer conditions at 6500 feet of runway used, the actual distance between the aircraft when it becomes airborne and the flight path of runway 18R is actually between 2000 and 3000 *feet*. Based on the speed of the aircraft, this distance would be covered in approximately 8-15 seconds - or less, depending on where the aircraft actually were to rotate on runway 27.

Consider this: In the time it takes for the average person to read and comprehend the paragraph above, an event of this nature could have already happened **TWICE**. Or more.

That means the controllers and flight crews involved have **ABSOLUTELY NO MARGIN FOR ERROR** provided they were able to respond at all. Controllers cannot be in the actual process of making a transmission to another aircraft or engaged in landline coordination with other operating positions. The radio exchange of information with the flight crews of both the go-around aircraft AND the aircraft landing 18R cannot be impeded by simultaneous radio calls (blocked transmissions) nor inadvertently missed by either flight crew, particularly the one in the go-around aircraft who will be VERY busy at the time. In short, *everything* has to be done **IMMEDIATELY AND PERFECTLY** by all parties involved or the **probability of a mid-air collision increases dramatically**.

Simply put, not every go-around occurs prior to the approach end of the runway, as the agency report would seemingly imply. We just don't get to pick and choose when these things happen, nor should we consider this highly probable outcome an acceptable risk.

LET ME BE CLEAR ON THIS POINT: The basic and unavoidable mathematical truth of this equation means the staggered ILS operation to runways 18L and 18R with Converging Runway Display Aid (CRDA) in use VIRTUALLY GUARANTEES A CONFLICT with traffic landing runway 18R should a late-stage or on-the-runway go-around occur on runway 27. Conditions and response times alone will determine the outcome.

Oddly enough, the agency position on this operation stands somewhat contradictory to a recent finding involving similar conflicts at Newark Liberty Airport, another matter brought forth by a whistleblower and mentioned in the report. The risk associated with the EWR operation was of sufficient concern to warrant alteration of the procedures in use. In that the Memphis scenario described above has an equal *OR POSSIBLY HIGHER* probability of midair collision, one *must* conclude that an operation deemed unsafe at Newark simply can't be considered safe at Memphis. It can't work in one place and not work in another.

This portion of the report also indicated Memphis ATCT management was provided with the opportunity to initiate a waiver request under FAA Order JO 1000.37 but chose not to. I applaud the decision not to pursue this but it must be noted that Memphis ATCT management had, *FOR YEARS*, told the air traffic controllers that the facility possessed "a waiver" that authorized the (illegal) 18L/27 operation that led to the initial AOV investigation and CRDA *despite actually knowing no such waiver ever existed.*

The safety study involving simultaneous arrivals to runways 18R and 27 was discontinued during this investigation because runway 27 had been closed for resurfacing. I consider it irresponsible for the agency to publish the conclusions made in the report on this particular topic without having completed that study. I first brought my concerns regarding this operation to FAA management during the training phase prior to CRDA implementation in 2007 and was ignored. Former Special Counsel Scott Bloch's September 08, 2008, letter to FAA documenting his concerns that this operation presented a substantial likelihood of a substantial and specific danger to public safety mandated a response within 60 days. This provided ample time for such a study to be completed prior to the closure of runway 27 for resurfacing. Why was the report not completed at that time? We simply cannot afford to delay matters of this nature. Eventually, rational thought will have to be given priority over Fedex profits at Memphis. I pray that day comes before people are killed in such an event.

Allegation 2: Violation of separation and wake turbulence minima for go-around traffic on runway 27 generated by traffic landing runway 18R, improper application of visual separation for wake turbulence encounters.

NOTE: For the non-aviation industry readers of this report, an explanation of wake turbulence is in order. Wake turbulence is an effect generated by an aircraft moving through the air, much as a car or truck displaces air, which in turn generates wind while driving down the road. This effect is most visible in rainy conditions when spray from the vehicle obstructs visibility as you drive next to it. With aircraft, the wake turbulence exists in the form of two, for lack of a better term, *horizontal tornadoes* that rotate inwards toward the center of the aircraft but trail and descend below and away from the aircraft. Direct encounters with wake turbulence from large and heavy jet aircraft is extraordinarily dangerous and potentially catastrophic to other aircraft. FAA has long established standards to avoid wake encounters that air traffic controllers must comply with. (Attachment 4)

Agency did not substantiate the existence of a wake turbulence encounter for *most* aircraft that go around on runway 27 but again failed to take into consideration the late-stage or after-touchdown go-around. These events DO happen. The event that triggered the original investigation and implementation of CRDA was just such an occasion. As with the situation regarding the mid-air collision risk to the runway 27 go-around aircraft noted in Allegation 1 of this report, runway 27 traffic *must* encounter wake turbulence generated by traffic landing either 18L (and possibly 18R) should the go around happen over runway 27. *It simply cannot be avoided.* The only difference is that the aircraft on runway 27 is flying into the side of the wake as opposed to operating behind it. This is yet another reason I feel the simultaneous or CRDA operation to runway 27 must be discontinued.

Consider the following scenario: Heavy jet (aircraft with a certificated minimum takeoff weight of 255,000 pounds or more) landing runway 18L. CRJ landing runway 27, CRDA in use. Per 7110.65 guidelines, a smaller regional jet also landing runway 18L. operating directly behind the heavy aircraft *must* be separated by a minimum of *5 miles* to avoid a wake encounter. In the converging (CRDA) scenario, the CRJ is approximately 2 miles east of the heavy jet's flight path and wake turbulence as it crosses the threshold for runway 27. Should a go-around be required for whatever reason once the CRJ is over runway 27, the flight path *will* intersect the heavy jet's wake turbulence just *two miles* behind the heavy jet - not the otherwise prescribed 5. This is also less than the prescribed separation for a CRJ landing directly behind another CRJ. Again, a very dangerous scenario the agency failed to include in their report. In this type of incident, the aircraft encountering the wake (from the side) would experience a sudden upward pitch of the nose, followed by a sudden downward pitch, a circumstance which may be repeated in reverse order just seconds later as the go-around aircraft enters, exits and re-enters the wake of the heavy. (See Diagram, Attachment 5)

Allegation 3: On at least two occasions, a supervisor stopped a controller from preventing a loss of separation between aircraft on approach. As a result, operational errors went unreported.

This report was substantiated by the agency.

Consider the impact of that allegation for a moment. *“Stopped a controller from preventing a loss of separation.”*

I am one of the controllers stopped from preventing a loss of separation.

This goes against everything the air traffic control system stands for. It also stands as a most appalling act of arrogance, incompetence and abuse of authority by an FAA manager. And this man still has his job, as do his superiors, who knew it was happening.

To provide background, I directly advised the supervisor, Herbert Brown, Jr., of an impending loss of separation. I advised him I was going to remove the aircraft from the landing sequence and asked him to coordinate with the radar controller to find out what heading they wanted the aircraft to be on when he was switched back for resequencing since traffic volume was fairly heavy and it appeared the standard go-around instructions were going to be less than optimal. Mr. Brown countermanded my decision and ordered me to allow the aircraft to continue the approach and land then subsequently failed to report or follow up on the loss of separation. When I came forward with my safety concern regarding this operation to another manager, that manager reported it to Operations Manager William Brinkley. When Mr. Brinkley researched the matter, Mr. Brown provided false testimony. Management refused to believe my statements, told me the errors that occurred were my fault, decertified me and threatened me with disciplinary action up to and including termination. Although my statements were corroborated over the next several days as other employees present at the time of the incident were interviewed, Memphis management refused to rescind their wrongful decertification then failed to provide me with proper recertification training, eventually demoting me to another facility at a significant cut in pay. I am at present pursuing remedy for that matter through the Equal Employment Opportunity process but the agency has not responded in a timely fashion to orders issued by the judge in the matter nor many requests from my attorney.

FAA’s Standard of Conduct and Discipline, Table of Penalties, assigns the following penalties to specific actions:

44. Making false or misleading statements in connection with any inquiry, investigation, etc., related to the safety of the NAS or flying public, for oneself or another.

First Offense: 60-day suspension to removal

46. Lack of candor; Failure to give complete and truthful information in connection with any inquiry, investigation, etc. related to the safety of the NAS or flying public.

First Offense: 30-day suspension to removal

These are just two of the MANY conduct violations Mr. Brown was conclusively guilty

of in this matter. Others included:

(First offense penalty follows the description)

9. Negligent or careless work performance, to include, creating an environment where credibility is questioned; inattention to duty.

Reprimand to 14-day suspension.

29. Failure to **immediately** report a violation of law, regulation or policy **to a manager, the servicing security organization, Administrator's Hotline, Inspector General, etc.**

Reprimand to 5-day suspension

30. Concealing or covering up an act that violates a DOT or FAA policy or program.

Reprimand to 10-day suspension

31. Failure or refusal by appropriate authority to correct or rectify a practice or situation that violates a DOT or FAA policy or program or to take appropriate action, to include discipline, when the facts are known and a corrective measure is warranted.

5 to 14-day suspension

50. Failure to immediately report an operational error or deviation.

Reprimand to 14-day suspension

51. Concealment of an operational error or deviation.

30-day suspension to removal

According to an earlier report, Mr. Brown received a *one-day suspension* for his actions in this matter. **ONE DAY.**

Not surprisingly, the agency did not include in their report that the other whistleblower (Peter Nesbitt) had reported to another manager at Memphis and the NASA Aviation Safety Reporting System that Mr. Brown was issuing orders of this nature APPROXIMATELY 4 MONTHS prior to my incident. (Attachments 6 & 7) Memphis management was already well aware it was happening and failed to take corrective action. Since this behavior was already known, Mr. Brown's actions become even more notorious and the egregiousness of the violation is thus intensified. In short, Mr. Brown's actions warranted the harshest penalty since loss of life was a possible outcome for his order and he knew it.

For the record, had I not complied with Mr. Brown's orders I would have been subject to disciplinary action that starts with a 14-day suspension.

The agency report indicates Mr. Brown has retired. This is not true. Mr. Brown withdrew his retirement request and returned to work at Memphis ATCT on January 19, 2010.

The final portion of the agency finding for this allegation concluded that, of the 232 air traffic events the first whistleblower (Nesbitt) reported as possible losses of separation or safety events, radar or audio replay of only about 30% (75 out of 232) of those incidents existed for review by the investigators. 35 of the 75 reviewed most likely represented an operational error. **This is an alarming 46%!** The finding also indicates that the Quality Assurance Review (QAR) process for one of the errors the investigators found failed to

identify the operational error and that proper documentation was not completed for the event. It has long been my unvoiced opinion that operational errors were underreported at Memphis. This troubling data, in addition to the NASA ASRS reports, only lends credence to that concern. The fate of the documentation for the remaining 157 events is also in question, OSC and the agency had ordered many records of this nature frozen yet Memphis was unable to provide them.

Allegation 4: Close calls during the midnight shift for aircraft crossing runway 27 in front of arriving or departing aircraft.

The agency report focused on two aspects of this concern – close calls or operational errors involving traffic crossing runway 27 in front of arrival or departure traffic and controller fatigue as a causal factor in the same.

The agency report stated they were unable to substantiate the existence of “close calls” with regards to traffic crossing runway 27 yet documentation I was recently provided (Attachments 8a, b, c: Facility logs for 1-6, 1-7 and 1-19-2010) indicates that aircraft crossing runway 27 in front of arriving traffic failed to clear on at least two occasions in January 2010, both requiring the landing aircraft to be sent around. While the controllers managed to prevent the simultaneous occupancy of the runway, the mere fact these events are indeed occurring indicates a failure by the agency to fully understand the nature of the problem or an unwillingness to see it for what it really is – dangerous. There was also a pilot deviation filed for a Fedex aircraft that crossed runway 27 without clearance recently, the facility log for that day is also attached (Attachment 9).

With regards to controller fatigue, I worked midnights on a rotating schedule for most of my eight years at Memphis. The agency report claiming they could not find violations of the required rest periods is, in my opinion, accurate. **THAT IS NOT THE ISSUE.** The issue at hand is that the circadian rhythm of the human body does not adapt well to the 2-2-1 (2 afternoons, two days, quick turn to the midnight shift) schedule and, despite a generally solid performance record on the midnight shift during my tenure at Memphis, I was *never* at my sharpest at 3:00 a.m. when the outbounds started, regardless of how much sleep I’d gotten the afternoon prior to my shift. Not being sharp when you’re tasked with Ground Control for the Fedex outbound is simply asking for trouble. The quick turn into the midnight shift might be legal but that doesn’t mean it is safe.

The decreased complexity of the midnight Fedex operation should not be construed as “easier”. The operation itself may be less complex but the volume makes it difficult in a different way.

It is my understanding that a “permanent mid crew” is being reinstated for 2010. This is a step in the right direction but will not eliminate the danger of being the “guest controller” on the mid. All one needs to do is think about how good their performance is *during the daytime* if you didn’t get a lot of sleep the night before. Do you want your surgeon wielding a scalpel on three hours of rest? Will an athlete play his best game with limited rest? Probably not. Air traffic control is entirely mental and performance is impacted by

many factors, the most important being fatigue. Training, overtime, personal matters and physical illness (among others) all contribute to fatigue and the agency is simply looking the other way despite their own fatigue studies that conclusively show these matters need to be addressed. The attached logs clearly show more problems are happening on the midnight shift than during the day. That is, in and of itself, a pretty strong indicator of the merit of this concern. The allegedly more complex daytime operation has a lower percentage of go-around and runway crossing problems. Why?

Allegations 5 and 9: ASDE/AMASS is not certified for use on runway 27, making it unusable for runway crossings (or taxi into position and hold (TIPH) operations).

This allegation was partially substantiated.

The issue I had concerns with was not addressed. Without a functional AMASS for runway 27, TIPH operations are only authorized if the aircraft on final to runway 27 are not cleared to land until the aircraft holding in position begins takeoff roll. During arrival operations, it was not uncommon for Local Control (LC) 3 to be combined with LC2, making the LC2 controller responsible for operations on 3 runways (36L, 36C, 27) and four different frequencies (including military UHF frequencies). If an aircraft on approach to runway 27 does not receive a landing clearance, *it is required to go around*. Frequently, the landing clearance has to be withheld until the aircraft is within a mile or two of the runway and the distinct possibility exists that subsequent frequency congestion or unexpected landline calls could distract the controller and the landing clearance could be forgotten or blocked by other transmissions, making the arrival into a go-around and putting two (or possibly three if there is a 36C or 36R departure) aircraft in close proximity over runway 27.

It is my recommendation that no traffic be authorized to TIPH under any circumstances on runway 27 if the LC3 position is combined to LC2 until ASDE3/AMASS is fully operational for runway 27. Typical QA reviews do not fully document the entirety of the situation so QA documentation might not necessarily indicate the specific cause of such a go-around. I believe the TIPH issue has been mitigated (not eliminated) significantly with time as the use of the operation became second nature but the problem was very real and a grave safety concern when it was first instituted roughly three years ago (prompting this now nearly three year old complaint). The agency position from the report on runway 27 AMASS/ASDE amounts to little more than a “cross your fingers and hope nothing happens until 2011” approach. They agree it is a problem but won’t do anything to mitigate it.

Allegation 6: Tailwind component exceeded for arriving and departing aircraft.

Agency partially substantiated this allegation.

My concern regarding the tailwind component is that management frequently deferred to Fedex request for runway configuration, even if it meant inconvenience or additional tailwind component for other operators. I personally believe the safety of the passenger

aircraft should take priority over Fedex profits or wishes when it comes to the runway configuration but wish to share a concern that the Fedex flight crews should have their safety considered as well. At times, that seems to be the last thing considered.

Allegation 7: Glare on STARS radar displays.

Agency report did not substantiate this allegation and noted Memphis Quality Assurance personnel determined that no such distraction had contributed to a loss of separation during a certification skill check.

Memphis' QA folks (none of which were operationally current in the radar room when I left Memphis) can say whatever they wish with regards to the cause of the operational error but there was absolutely no question glare was a factor on the West Arrival (ARW) scope nearest the door to the TRACON. This was sometimes from the overhead lighting, frequently from the light in the hallway when the door was opened and occasionally from the overhead lighting at the supervisor's desk. I do not personally recall having a problem with glare at any other scope but that doesn't mean it didn't exist. The basic aspects of light reflection were most likely not considered by the QA staff in this matter but the amount of reflected light observed by a 5' 6" person will be different than that observed by someone who is 6'. It will be entirely dependent on the relationship between the light source, the angle of the glass and the location of the individual seated at the scope.

As noted in allegation 3, QA staff at Memphis failed to do their job properly with regards to operational error reporting and investigation. Support Manager Robert "Bobby" Parker was personally involved in an operational error that he attempted to cover up a number of years ago. He has made it no secret that he desperately wants to know who called the error in to the Administrator's Hotline, presumably for the intent of payback. It is my belief that ANY input he provided for the agency report should be viewed with enormous skepticism as his integrity and credibility, destroyed by his own actions, is simply nonexistent. His disdain for the air traffic workforce is not a secret - he personally stated to me that our complaints (the whistleblowers) regarding the safety of the runway 27 operations amounted to our "peeing in our sugar". Since he is responsible for the QA staff at Memphis, the credibility of the entire QA workforce product must be considered suspect from the outset regardless of the efforts or diligence of his subordinate employees because he gets the final say on what that product is. It is my opinion his continued presence at Memphis ATCT is an invitation to retaliation and abuse of authority.

Allegation 8: Aircraft departing Class B Airspace not notified by controllers.

Agency substantiated this allegation.

No comment on this issue.

FAA PROCESS FOR REPORTING AND INVESTIGATING OPERATIONAL ERRORS:

Agency reported that OE reporting problems at Dallas-Fort Worth were not systemic and offered proof in the form of a study done at OEDP capable sites.

My initial reaction to this portion of the report is one of enormous skepticism. My current facility has had any number of problems with the terminal version of OEDP software (TARP), from nonexistent separation losses to so many conflict alarms as to be unreasonable to track them all. In a busy terminal environment, there will be hundreds of incidents daily where the core ATC separation of 1000 feet and three miles is not maintained, be it for visual separation or other approved methods. There just aren't enough people on staff to investigate them all so they're holding off formal implementation until the agency can find a fix for the majority of the extraneous alarms.

Given the extraordinary number of items the investigators found at Memphis with regards to just Allegation 3 above, the probability there are other facilities out there underreporting operational errors is most likely significantly higher than the report would indicate, especially at facilities that do not yet have any OEDP or TARP capability. With the recent (entirely too frequent) "rebaselining" of operational error standards, the FAA has also created a false sense of progress in reducing the number of operational errors as many events previously classified as OEs are now not classified as errors at all, skewing the statistics to create the appearance of error reduction.

In the report, the agency's own numbers indicate 46% of the data Mr. Nesbitt submitted - for which they were able to obtain full or partial playback information - most likely represented operational errors. Application of that approximate baseline for accuracy to the entirety of the 232 events he reported would mean that nearly 107 operational errors may have gone unreported at Memphis.

That is not an insignificant fraction. A "plus or minus" of 2-3 percent might be considered such but nearly half? Using that percentage, if Memphis was added to the study list of facilities the DOT IG actually visited (3 of the 13 named in the study were not visited) and pulled QAR/OEDP data for, the roughly 1% the agency study indicated would jump to nearly 25%!

That would indicate a systemic problem. Keep in mind that Mr. Nesbitt's documentation only covered the shifts he was working, there were between 120-128 hours a week *he wasn't there*.

SUMMARY

Agency report failed to properly and specifically address significant portions of a number of the allegations made, the result being the specific issues raised by the whistleblowers remain uninvestigated, unresolved and still represent a likely and specific danger to the public - more than three years after many of them were first reported to FAA management at the local, regional or national level.

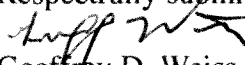
Whistleblower's Final Comments

There is an over-arching aspect to the agency report that, in my opinion and beyond the safety issues, does not get nearly the attention it deserves. The real systemic problem that touches most of the issues at Memphis is an abject failure on the part of Memphis facility management to properly do their jobs. The QA department is led by an individual (Bobby Parker) who was caught covering up his own operational error and issued false testimony while a member of management. Frontline managers violate law, rule and order and get caught providing false statements or incomplete/inaccurate documents, only to face little or no accountability for their actions because the facility level manager has a large say in the way in what discipline (if any) will be meted. On the other hand, these same individuals who have clearly displayed their lack of credibility and objectivity maintain oversight and decision-making responsibility for performance and disciplinary matters of the very people who discovered and reported their violating the rules. The situation is rife with retaliatory potential, the appearance (or actual existence) of which is so common as to have a chilling effect on employees who would otherwise come forward with more problems. It is every bit an us-against-them "good ole boy"-type network that is failing the taxpayers and placing the flying public at the ultimate risk.

In that context, consider that BOTH of the whistleblowers that initiated this report were decertified under eerily similar and at-best questionable circumstances and demoted to lower level facilities under threat of termination, after Memphis management made it clear that they were unhappy with the whistleblowers for their reporting of problems.

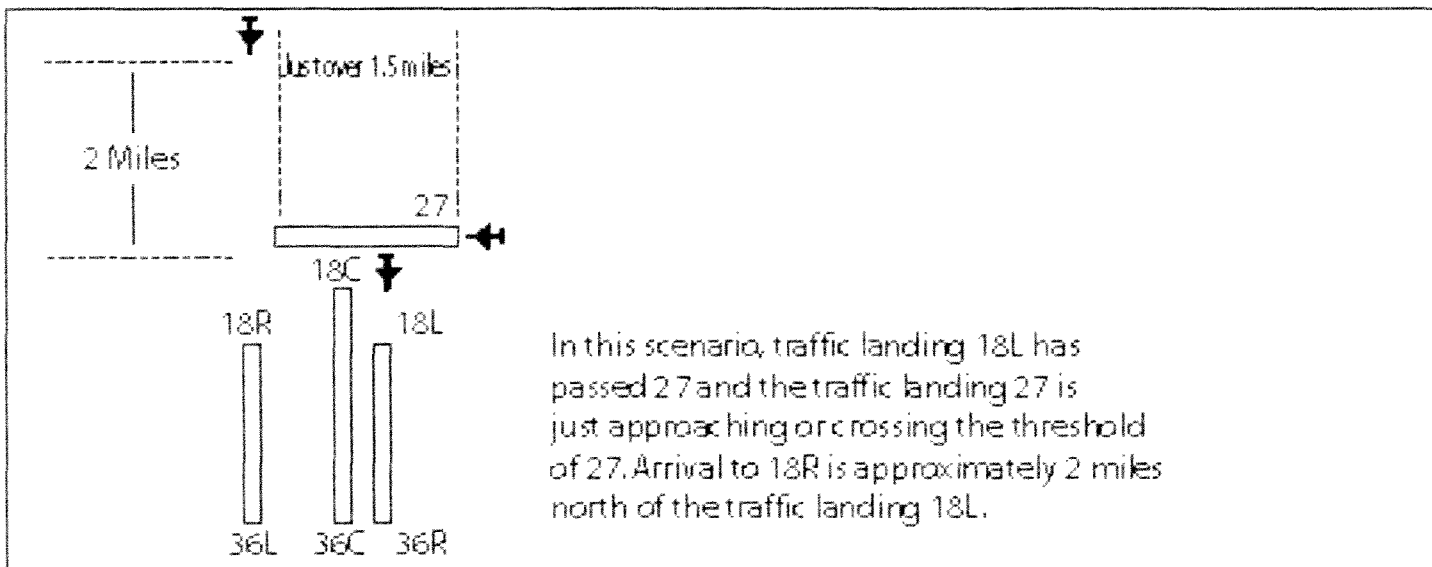
This appears to be the FAA's *modus operandi* for dealing with those who come forward to enhance safety margins. Rather than addressing the problems head on with the assistance of the whistleblower, the agency instead buries the problems or the people who report them for unexplained reasons. The potential for and costs associated with catastrophic results stemming from the approach the agency has taken in matters like these far outweighs any perceived benefit. Protected by a cumbersome and lengthy process that more often leads to the disillusionment of the whistleblower rather than the resolution of problems, the agency is given little or no motivation to change the way it does business. We, as whistleblowers, are out here. We are documenting these safety lapses and reporting them to an agency that needs to correct them, not punish us. Should the negligent approach it currently embraces be exposed through tragedy, who will be held accountable? Doesn't it make more sense to fix the \$20 problems and avoid the million dollar litigations? We shouldn't be waiting for people to die to make changes.

Respectfully submitted this 3rd day of February, 2010.

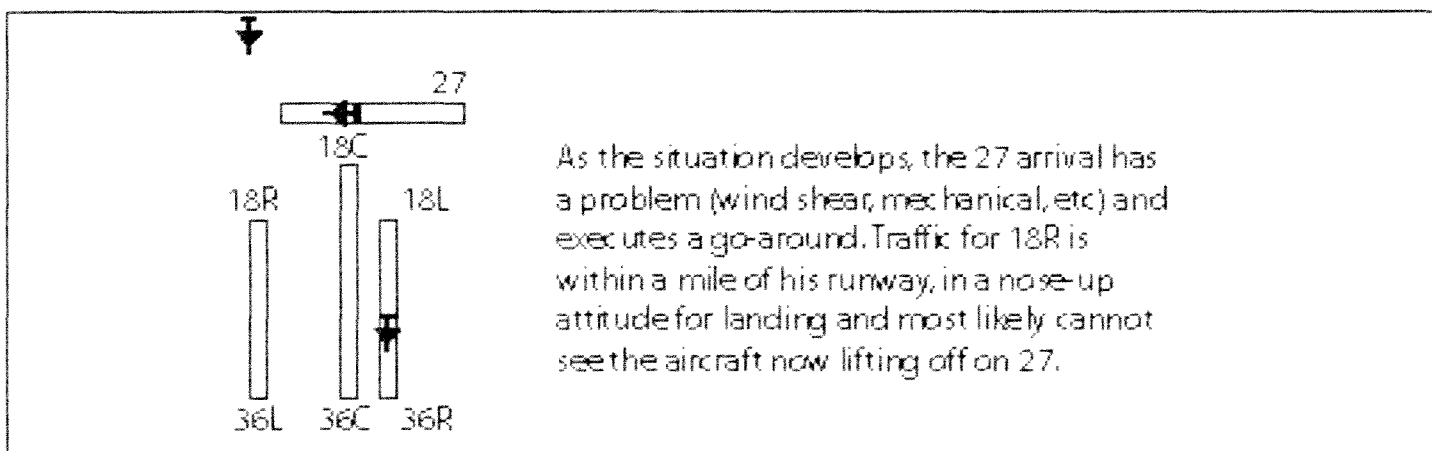

Geoffrey D. Weiss
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Fernandina Beach, FL 32034

ATTACHMENT 1

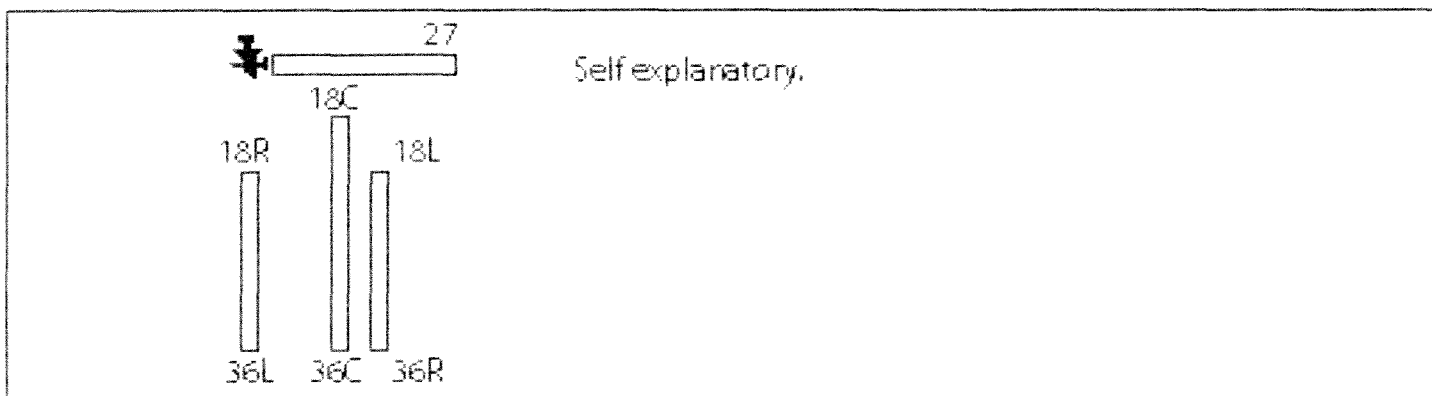
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Notes: Typical speed on final for the commercial aircraft used by NWA and FDX at MEM will be between 110-160 knots, or between 2 to 2.5 miles per minute. This will vary with the wind, pilot and airspeed instructions issued by ATC. In this case, assuming a higher speed by the aircraft landing 18R and acceleration of the traffic on 27 back up to that which will allow the aircraft to get airborne, with the hope that the crew of the 27 traffic has notified ATC of the go-around in anywhere close to a reasonable amount of time, there will be somewhere in the vicinity of 20 seconds for the controller to recognize the situation, notify the controller working the traffic landing 18R and all necessary actions to prevent the midair to get issued and responded to by the crews - IF everything happens just right and another aircraft isn't checking on to one (or both) of the frequencies at the the time, blocking the requisite transmissions. This is the swiftest version of Russian roulette.

DAILY RECORD OF FACILITY OPERATION

Location: MFM TOWER
 Position: Atty.
 Area: MFM

Manager: Mike Baker
 Date: 12/22/2009
 Checked By: _____

Inr	Area	Type	Time	Remarks
WR	OPERATIONS		06:00	T. WEBER ON, RWY 18 AND 27 IN USE.
WR	OPERATIONS		06:52	RWY 27 IN USE.
WR	OPERATIONS		07:30	RWY 18 AND 27 IN USE.
WR	OPERATIONS		09:49	INITIATED 4 HR DROP INTERVAL
GC	OPERATIONS		11:50	G. CLEARY ON, ABV NOTED
GC	OPERATIONS		13:06	WCLC.
GC	OPERATIONS		13:37	MONITORED POSITION RELIEF BRIEFING ON GC2
GC	OPERATIONS		13:46	MONITORED POSITION RELIEF BRIEFING ON GC1.
GC	OPERATIONS		14:50	RWY 27 RLSD TO GC.
GC	OPERATIONS		17:54	RWY 18R/C/L AND 27 IN USE
CS	OPERATIONS		19:28	C. WILLIS ON, ABOVE NOTED.
CS	OPERATIONS		20:36	WCLC
JA	OPERATIONS		21:45	RWY 27 RLSD TO GC.
JA	OPERATIONS		22:00	J. SHORT ON, RWY 18L/C/R
JA	OPERATIONS	O	01:30	FLO3951 INBOUND RWY36 WITH GEAR PROBLEMS. ALERT 1 CALLED AT 2358Z. LANDED 2701 AT 0007Z. ALERT 1 ENCLD AT 0010Z. FLO3951 HAD GEAR PINNED THEN TAXI'D TO THE GATE.
JA	OPERATIONS		00:44	MONITORED POSITION RELIEF BRIEFING, LC2
JA	OPERATIONS		01:51	MONITORED POSITION RELIEF BRIEFING, LC2
JA	OPERATIONS		02:13	DEAD COYOTE FOUND ON RWY 18R. NWA2453 IS BELIEVED TO HAVE HIT IT. NWA2453 WAS ADVISED.
DT	OPERATIONS		02:20	D. THORNTON ON.
DT	OPERATIONS		03:20	RWY 27 IN USE.
GC	OPERATIONS		04:00	G. CLEARY ON, ABV NOTED.
GC	OPERATIONS		04:16	WCLC.
GC	OPERATIONS	O	05:25	PILOT INITIATED GO AROUND RWY 27 FOX 1210 MD11
GC	OPERATIONS		05:59	COB

I certify that entries above are correct, that all scheduled operations have been accomplished except as noted, and that all abnormal occurrences and conditions have been reported.

Signature(s) of watch supervisor(s): _____

DAILY RECORD OF FACILITY OPERATION

ATTACHMENT 3

Location: MEM TOWER
 Position: All
 Area: MEM

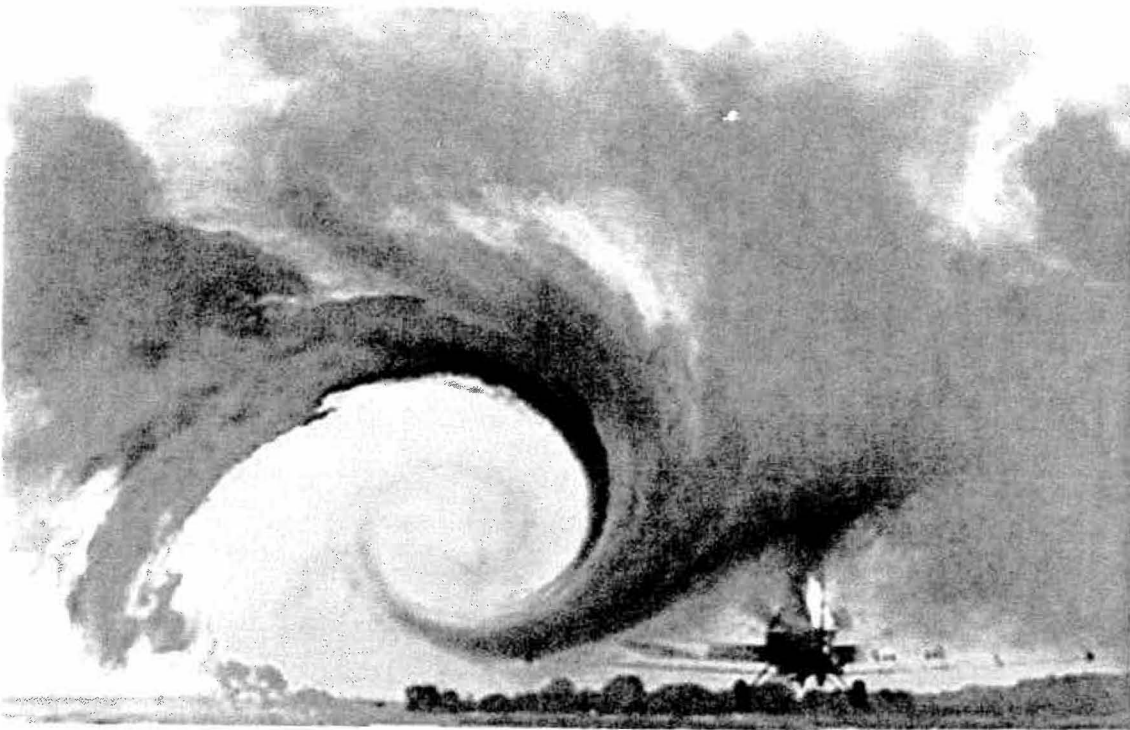
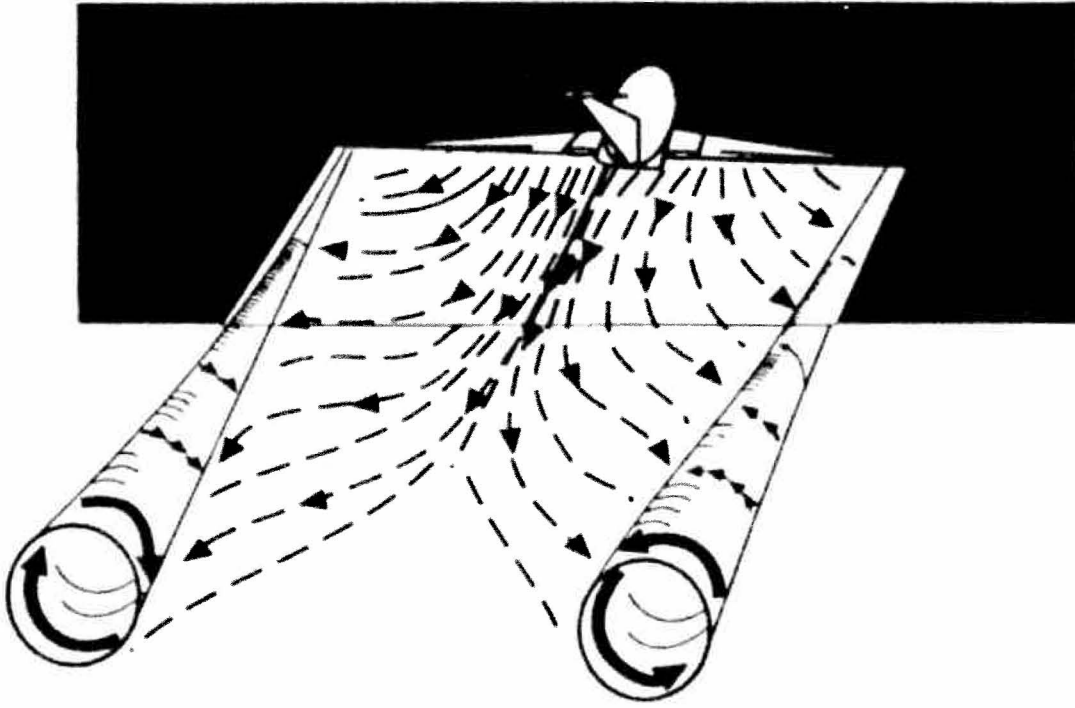
Manager: Mike Baker
 Date: 12-8-2009
 Checked By: _____

Ini	Area	Type	Time	Remarks
WR	OPERATIONS		06:00	L. WEBBER ON, RY 36 IN USE, RY 27 BELONGS TO GC.
CB	OPERATIONS	Q	06:12	FDX2225 DC10 EXECUTED A GO AROUND ON A 3 MI FINAL RYWY 18R DUE TO 32 KT WIND SPEED INDICATION.
CB	OPERATIONS	Q	06:12	FDX2225 DC10 EXECUTED A GO AROUND ON A 3 MI FINAL RYWY 18R DUE TO 32 KT WIND SPEED INDICATION.
WR	OPERATIONS		07:19	MONITORED POSITION RELIEF BRIEFING.
WR	OPERATIONS		07:33	RY 18L OR AND 27 IN USE.
CB	OPERATIONS		11:56	C. BYRD ON.
CB	OPERATIONS		12:37	RWY CHG: RWY'S 36L R, 18L S IN USE.
CB	OPERATIONS		13:00	WCLC.
CB	OPERATIONS		14:32	MONITORED POSITION RELIEF BRIEFING LC1.
CB	OPERATIONS		14:35	RWY CHG: RWY'S 18L R, 18L S IN USE. DEPTS RESD HDG 090-270 FOR WX.
CB	OPERATIONS		15:08	MONITORED POSITION RELIEF BRIEFING LC2.
WR	OPERATIONS		15:38	NORMAL DEPT HDGS.
JA	OPERATIONS		18:45	J. SHORT ON, RWY 18L OR, RWY 27 RESD TO GC.
JA	OPERATIONS		19:08	AMASS IN RAIN MODE.
JA	OPERATIONS		19:13	MONITORED POSITION RELIEF BRIEFING LC2.
JA	OPERATIONS		20:40	WESTBOUND DEPT DEVIATING HEADING 180 TO 270. EASTBOUND DEPT DEVIATING HEADING 090 TO 185. DEVIATING FOR WEATHER.
JA	OPERATIONS		22:44	TOLD FDX TO HOLD ALL DEPTS AT THE SPOTS DUE TO TRAFFIC WAITING TO DEPT AND CHANGING TO OUTBOARDS FOR AFFAIRS. WEATHER IN THE AREA IS GOING TO BE IN USE AND IT'S CRITICAL AREAS NEEDED TO BE PROTECTED.
JA	OPERATIONS		22:59	ADVISED FDX THE COULD RESUME DEPTS.
JA	OPERATIONS		23:20	WESTBOUND DEPTS HEADING 180 FOR WIND. NORMAL DEPT HEADINGS EASTBOUND.
JA	OPERATIONS		01:50	AMASS NORMAL MODE.
JA	OPERATIONS		02:08	RYWY 27 RETURNED TO LC.
IC	OPERATIONS		02:25	J. COLYER IS ON, ABV NOTED.
CB	OPERATIONS		04:00	C. BYRD ON.
CB	OPERATIONS		04:08	WCLC.
CB	OPERATIONS	Q	04:38	ALERT 2. DAL 1685, 11900 #S FULL. 111 SQB, NO ANTI-SKID. ACFT LANDED RWY 18L AT 0452. WCL ALERT SECURED.
CB	OPERATIONS		05:03	VA'S RWY 18L OR/27 CRDA IN USE.
CB	OPERATIONS	Q	05:36	FDX2271 WAS SENT AROUND RWY 18L FOR CRDA SPACING WITH AT 72 FN RWY 27 S-H. WIND 240/12. WIND AT 2000 250/10.
CB	OPERATIONS		05:50	MONITORED POSITION RELIEF BRIEFING LC3.
CB	OPERATIONS		05:59	COB.

I certify that entries above are correct and that all scheduled operations have been accomplished except as noted and that all abnormal occurrences and conditions were properly reported.

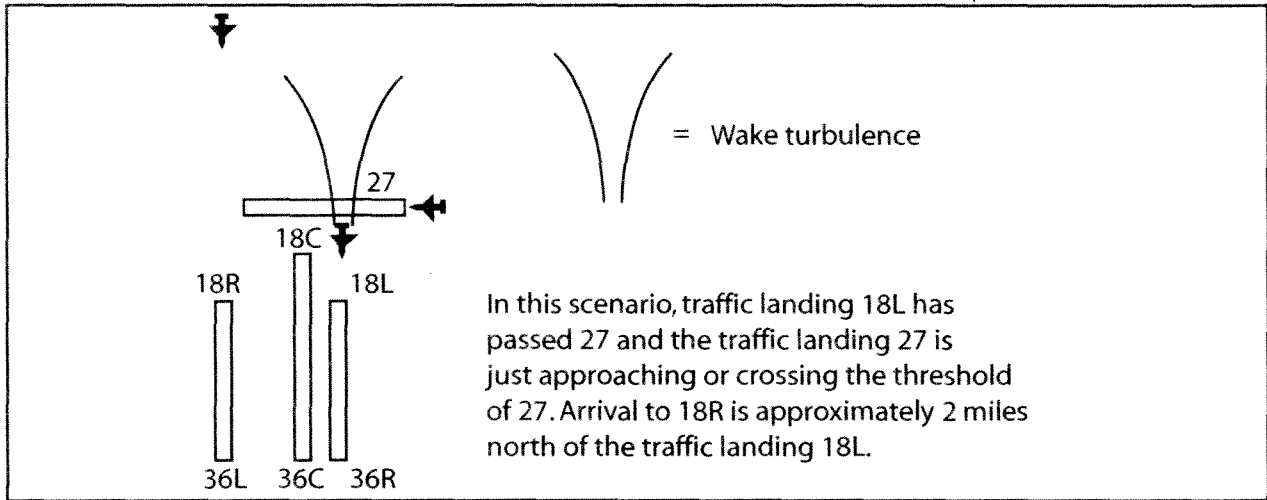
Signature(s) of watch supervisor(s)

ATTACHMENT 4

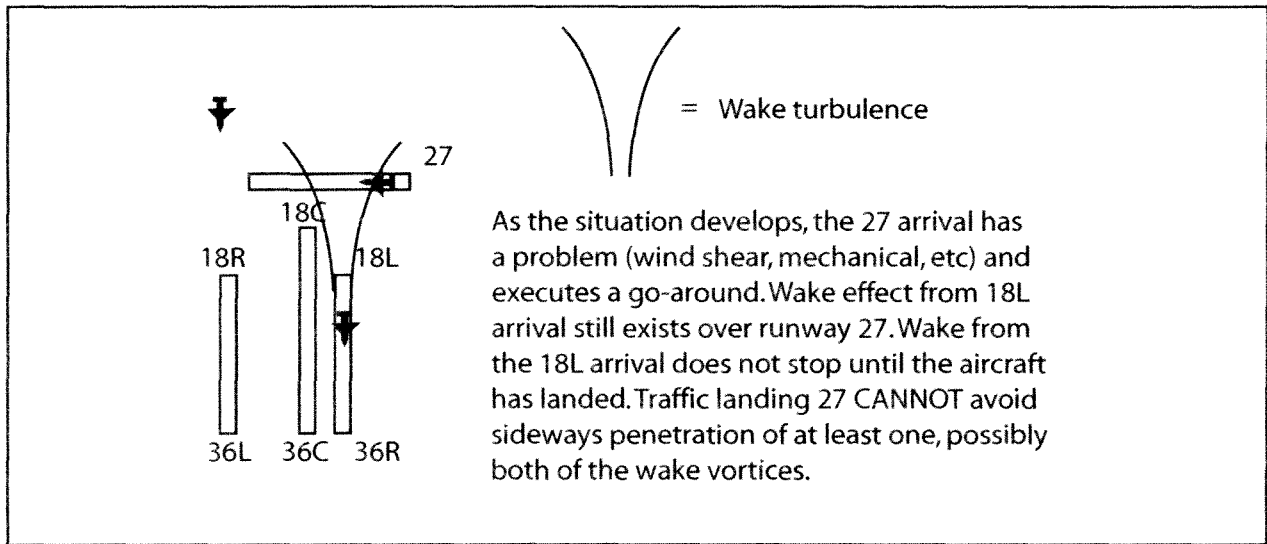


ATTACHMENT 5

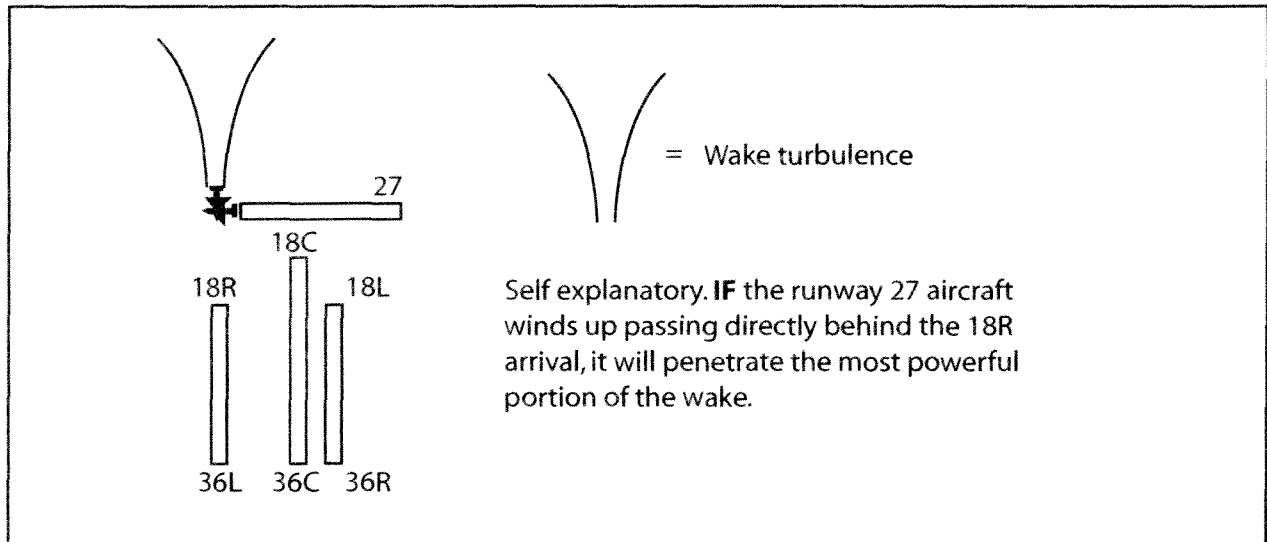
1



2



3



A

ATTACHMENT

6

DO NOT REPORT AIRCRAFT ACCIDENTS AND CRIMINAL ACTIVITIES ON THIS FORM.
ACCIDENTS AND CRIMINAL ACTIVITIES ARE NOT INCLUDED IN THE ASRS PROGRAM AND SHOULD NOT BE SUBMITTED TO NASA.
ALL IDENTITIES CONTAINED IN THIS REPORT WILL BE REMOVED TO ASSURE COMPLETE REPORTER ANONYMITY.

IDENTIFICATION STRIP: Please fill in all blanks to ensure return of strip.
 NO RECORD WILL BE KEPT OF YOUR IDENTITY. This section will be returned to you.

(SPACE BELOW RESERVED FOR ASRS DATE/TIME STAMP)

TELEPHONE NUMBERS where we may reach you for further details of this occurrence:

HOME Area 512 No. 791-7089 Hours 24
WORK Area 0 No. 000-0000 Hours 00

NAME Peter D. Nesbitt

ADDRESS/PO BOX 56 N. McLean Blvd., #3

CITY Memphis **STATE** TN **ZIP** 38104

TYPE OF EVENT/SITUATION

Separation Error

DATE OF OCCURRENCE 10/16/2006
(MM/DD/YYYY)

LOCAL TIME (24 hr. clock) 16:15
(HH:MM)

PLEASE FILL IN APPROPRIATE SPACES AND CHECK ALL ITEMS WHICH APPLY TO THIS EVENT OR SITUATION.

REPORTER

In what type of facility do you work? Tower Approach Center FSS Facility ID MEM

Describe your ATC qualifications. FPL Developmental Time certified on position/sector: 1.00 yrs/mos

What is your ATC experience in years? radar 18.00 limited radar _____ non-radar _____ military 4.00 supervisor _____

What was your control position or activity during the occurrence? (Check all that apply for combined position)
 radar local arrival clrcn delivery pre-flight supervisor
 hand-off ground departure coordinator in-flight monitor
 radar assoc assistant data manual flight watch other _____

Was instruction a factor? I was instructing I was receiving training yes no **Reset**

Do you have pilot experience? no yes, _____ hours **Reset** instrument rated

AIRSPACE

- Class A (PCA)
- Class B (TCA)
- Class C (ARSA)
- Class D (Control Zone/ATA)
- Class E (General Controlled)
- Class G (Uncontrolled)
- Special Use Airspace
- airway/route _____
- unknown/other None

WEATHER

- VMC
- IMC
- mixed
- marginal
- rain
- fog
- ice
- snow
- turbulence
- thunderstorm
- windshear

LIGHT/VISIBILITY

- daylight night
- dawn dusk
- ceiling 700 feet
- visibility 0.50 miles
- RVR _____ feet

AIRCRAFT 1

AIRCRAFT 2

Type of Aircraft	(Make/Model) <u>PA32</u>	(Make/Model) <u>MD80</u>
Operator	<input type="checkbox"/> air carrier <input type="checkbox"/> military <input type="checkbox"/> corporate <input type="checkbox"/> commuter <input checked="" type="checkbox"/> private <input type="checkbox"/> other _____	<input checked="" type="checkbox"/> air carrier <input type="checkbox"/> military <input type="checkbox"/> corporate <input type="checkbox"/> commuter <input type="checkbox"/> private <input type="checkbox"/> other _____
Mission	<input type="checkbox"/> passenger <input type="checkbox"/> training <input type="checkbox"/> business <input type="checkbox"/> cargo <input type="checkbox"/> pleasure <input checked="" type="checkbox"/> unk/other _____	<input checked="" type="checkbox"/> passenger <input type="checkbox"/> training <input type="checkbox"/> business <input type="checkbox"/> cargo <input type="checkbox"/> pleasure <input type="checkbox"/> unk/other _____
Flight plan	<input type="checkbox"/> VFR <input type="checkbox"/> SVFR <input type="checkbox"/> none <input checked="" type="checkbox"/> IFR <input type="checkbox"/> DVFR <input type="checkbox"/> unknown	<input type="checkbox"/> VFR <input type="checkbox"/> SVFR <input type="checkbox"/> none <input checked="" type="checkbox"/> IFR <input type="checkbox"/> DVFR <input type="checkbox"/> unknown
Flight phases at time of occurrence	<input type="checkbox"/> taxi <input type="checkbox"/> cruise <input type="checkbox"/> landing <input type="checkbox"/> takeoff <input type="checkbox"/> descent <input type="checkbox"/> missed apch/GAR <input type="checkbox"/> climb <input checked="" type="checkbox"/> approach <input type="checkbox"/> other _____	<input type="checkbox"/> taxi <input type="checkbox"/> cruise <input type="checkbox"/> landing <input type="checkbox"/> takeoff <input type="checkbox"/> descent <input type="checkbox"/> missed apch/GAR <input type="checkbox"/> climb <input checked="" type="checkbox"/> approach <input type="checkbox"/> other _____
Control status	<input type="checkbox"/> visual apch <input type="checkbox"/> on vector <input type="checkbox"/> on SID/STAR <input checked="" type="checkbox"/> controlled <input type="checkbox"/> none <input type="checkbox"/> unknown <input type="checkbox"/> no radio <input type="checkbox"/> radar advisories	<input type="checkbox"/> visual apch <input type="checkbox"/> on vector <input type="checkbox"/> on SID/STAR <input checked="" type="checkbox"/> controlled <input type="checkbox"/> none <input type="checkbox"/> unknown <input type="checkbox"/> no radio <input type="checkbox"/> radar advisories

If more than two aircraft were involved, please describe the additional aircraft in the "Describe Event/Situation" section.

LOCATION

CONFLICTS

Altitude 1,000 MSL AGL
Distance and radial from airport, NAVAID, or other fix
2 NM South of MEM VOR
Nearest City/State Memphis, TN

Estimated miss distance in feet: 1 0
 Was evasive action taken? Yes No
 Was TCAS a factor? Yes No
 Did Conflict Alert Activate? Yes No

ATTACHMENT 6

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

AVIATION SAFETY REPORTING SYSTEM

NASA has established an Aviation Safety Reporting System (ASRS) to identify issues in the aviation system which need to be addressed. The program of which this system is a part is described in detail in FAA Advisory Circular 00-46D and FAA Handbook 7210.3. Your assistance in informing us about such issues is essential to the success of the program. Please fill out this form as completely as possible, enclose in an sealed envelope, affix proper postage, and send it directly to us.


Section 91.25 of the Federal Aviation Regulations (14 CFR 91.25) prohibits reports filed with NASA from being used for FAA enforcement purposes. This report will not be made available to the FAA for civil penalty or certificate actions for violations of the Federal Air Regulations. Your identity strip, stamped by NASA, is proof that you have submitted a report to the Aviation Safety Reporting System. We can only return the strip to you, however, if you have provided a mailing address. Equally important, we can often obtain additional useful information if our safety analysts can talk with you directly by telephone. For this reason, we have requested telephone numbers where we may reach you.

The information you provide on the identity strip will be used only if NASA determines that it is necessary to contact you for further information. THIS IDENTITY STRIP WILL BE RETURNED DIRECTLY TO YOU. The return of the identity strip assures your anonymity.

Thank you for your contribution to aviation safety.

NOTE: AIRCRAFT ACCIDENTS SHOULD NOT BE REPORTED ON THIS FORM. SUCH EVENTS SHOULD BE FILED WITH THE NATIONAL TRANSPORTATION SAFETY BOARD AS REQUIRED BY NTSB Regulation 830.5 (49CFR830.5).

If you want to mail this form, please fold both pages (and additional pages if required), enclose in a sealed, stamped envelope, and mail to:

 NASA AVIATION SAFETY REPORTING SYSTEM
POST OFFICE BOX 189
MOFFETT FIELD, CALIFORNIA 94035-0189

If you wish to submit online, click the **Submit** button at the bottom of page 2 or 3 when complete.

DESCRIBE EVENT/SITUATION

Keeping in mind the topics shown below, discuss those which you feel are relevant and anything else you think is important. Include what you believe really caused the problem, and what can be done to prevent a recurrence, or correct the situation. (USE ADDITIONAL PAPER IF NEEDED)

While working Ground Control 2 (GC2) during the beginning of an arrival push at MEM, I observed a loss of separation that went unreported when brought to the attention of the Tower Supervisor. Approach was running "Staggered Approaches" to RWY 36L and 36R. Final West (ARF) and Final East (ARM) were both open. N884CC, a PA32 was on the ILS RWY 36R. AAL282, an MD80 was on approach to RWY 36L. The MD80 was gaining on the PA32, and the required 2 mile stagger spacing was going to be lost. The Local Control 2 (LC2) Controller told the Supervisor that he was going to break-out the PA32, but the Supervisor directed the LC2 Controller to "let it ride". Separation was lost, and no one did anything about it. Our facility is involved in a "competition" with several other facilities that have had an "excessive" number of operational errors. It is my impression that MEM Management does not want to report any errors so that we may win the award and allow the Facility Manager to look good for his superiors. Several other Controllers have reported Operational Errors, but after investigation, it was found that no error occurred.

CHAIN OF EVENTS

- How the problem arose
- How it was discovered
- Contributing factors
- Corrective actions

HUMAN PERFORMANCE CONSIDERATIONS

- Perceptions, judgments, decisions
- Actions or inactions
- Factors affecting the quality of human performance

A

ATTACHMENT

7

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IDENTIFICATION STRIP: Please fill in all blanks to ensure return of strip. NO RECORD WILL BE KEPT OF YOUR IDENTITY. This section will be returned to you.

(SPACE BELOW RESERVED FOR ASRS DATE/TIME STAMP)

TELEPHONE NUMBERS where we may reach you for further details of this occurrence:

HOME Area 512 No. 791-7089 Hours 24
WORK Area 0 No. 000-0000 Hours 00

NAME Peter D. Nesbitt
ADDRESS/PO BOX 56 N. McLean Blvd., #3
CITY Memphis STATE TN ZIP 38104

TYPE OF EVENT/SITUATION Loss of Separation
DATE OF OCCURRENCE 10/16/2006
LOCAL TIME (24 hr. clock) 17:00

PLEASE FILL IN APPROPRIATE SPACES AND CHECK ALL ITEMS WHICH APPLY TO THIS EVENT OR SITUATION.

REPORTER

In what type of facility do you work? Tower Approach Center FSS Facility ID MEM
Describe your ATC qualifications. FPL Developmental Time certified on position/sector: 1.00 yrs/mos
What is your ATC experience in years? radar 18.00 limited radar non-radar military 4.00 supervisor
Was instruction a factor? I was instructing I was receiving training yes no Reset
Do you have pilot experience? no yes, hours instrument rated

AIRSPACE

WEATHER

LIGHT/VISIBILITY

Class A (PCA) Class B (TCA) Class C (ARSA) Class D (Control Zone/ATA) Class E (General Controlled) Class G (Uncontrolled)
Special Use Airspace airway/route unknown/other None
VMC IMC mixed marginal rain fog ice snow turbulence thunderstorm windshear
daylight night dawn dusk ceiling 700 feet visibility 1.00 miles RVR feet

AIRCRAFT 1

AIRCRAFT 2

Type of Aircraft (Make/Model) Twin Engine Turboprop (BE20?) (Make/Model) Turbojet (MD80?)
Operator air carrier military corporate commuter private other
Mission passenger training business cargo pleasure unk/other
Flight plan VFR SVFR none IFR DVFR unknown
Flight phases at time of occurrence taxi cruise landing takeoff descent missed apch/GAR climb approach other
Control status visual apch on vector on SID/STAR controlled none unknown no radio radar advisories

If more than two aircraft were involved, please describe the additional aircraft in the "Describe Event/Situation" section.

LOCATION

CONFLICTS

Altitude 1,500 MSL AGL
Distance and radial from airport, NAVAID, or other fix 2.0 NM North of MEM Airport
Nearest City/State Memphis, TN
Estimated miss distance in feet: horiz 1 vert 0
Was evasive action taken? Yes No
Was TCAS a factor? Yes No
Did Conflict Alert Activate? Yes No

ATTACHMENT

7

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

AVIATION SAFETY REPORTING SYSTEM

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DESCRIBE EVENT/SITUATION

Keeping in mind the topics shown below, discuss those which you feel are relevant and anything else you think is important. Include what you believe really caused the problem, and what can be done to prevent a recurrence, or correct the situation. (USE ADDITIONAL PAPER IF NEEDED)

While working Ground Control 1 (GC1) today I observed a loss of separation on Final that went unreported. This loss of separation was caused by the Supervisor allowing a situation to develop, and essentially saying that the Tower was providing visual separation, when the weather conditions prevented either aircraft from being in sight.

A twin-engine aircraft was on final for RWY 18R with a Turbojet staggered behind the twin for RWY 18L. Based on the runway distance criteria, we the Final Controller must maintain a 2.0 NM stagger all the way down the final approach until 1 mile from the runway, or until the Local Controller can provide Visual Separation. The turbojet was gaining on the twin when the Local Control 1 (LC1) Controller indicated that someone needed to break-out one of the two aircraft where separation was being lost. Neither aircraft was talking to the Tower at the time this remark was made. The two aircraft check in with LC1 and LC2, and the 2.0 NM stagger was subsequently lost. The LC2 Controller indicated that he was going to break the turbojet out and send that aircraft around, but the Supervisor said "I've got the twin in sight." Someone in the Tower told the Supervisor that he had to have both aircraft in sight in order to provide visual separation. The Supervisor then stated, "I have them both in sight."

No one in the Tower Cab could see either aircraft until each was on short final for their respective runways. Management insists that we run a "safe" operation, adhering to the rules and regulations at all times. They will violate us in heartbeat for any minor indiscretion when it suits their agenda, but we have situations like this were management will allow a loss of separation to take place at their whim and discretion.

CHAIN OF EVENTS

- How the problem arose
- How it was discovered
- Contributing factors
- Corrective actions

HUMAN PERFORMANCE CONSIDERATIONS

- Perceptions, judgments, decisions
- Actions or inactions
- Factors affecting the quality of human performance

DAILY RECORD OF FACILITY OPERATION

Location: MEM TOWER
 Position: ALL
 Area: MEM

Manager: Mike Baker
 Date: 1/6/2010
 Checked By: _____

Ini	Area	Type	Time	Remarks
GC	OPERATIONS		06:00	G. CLEARY ON. WCLC, RWY 36L/C/R AND 27 IN USE.
GC	OPERATIONS		06:11	RWY 9 IN USE
GC	OPERATIONS	Q	06:38	GO AROUND RWY 9 FDX1215 MD11 FOR A/C ON RWY
GC	OPERATIONS		07:00	RWY 27 IN USE.
GC	OPERATIONS		08:01	RWY 18L/C/R 27 IN USE
GC	OPERATIONS		10:45	MONITORED POSITION RELIEF BRIEFING LC3
JA	OPERATIONS		11:45	J SHORT ON RWY 36L/C/R/27
JA	OPERATIONS		13:23	WCLC
JA	OPERATIONS		13:54	MONITORED POSITION RELIEF BRIEFING GC1.
JA	OPERATIONS	Q	15:25	1 RL155 F 145 ABORTED DEPT RWY 36C. THRUST LEVER WARNING LGT. BM AT ROCC ADVISED.
JA	OPERATIONS		15:08	MONITORED POSITION RELIEF BRIEFING LC1.
CB	OPERATIONS		16:20	C WILLIS ON
CB	OPERATIONS		18:42	C BYRD ON
CB	OPERATIONS		19:17	WCLC.
CB	OPERATIONS		19:35	RWY CHG. RWY'S 18L/R/27, VA'S IN USE.
CB	OPERATIONS		00:22	MONITORED POSITION RELIEF BRIEFING GC2.
CB	OPERATIONS		00:47	MONITORED POSITION RELIEF BRIEFING GC1
CB	OPERATIONS		02:14	C MATHIS ON
JA	OPERATIONS		04:00	J SHORT ON RWY 36L/C/R/27.
JA	OPERATIONS	Q	05:20	FDX1212 H/A306 SENT AROUND RWY 27. TRAFFIC CROSSING RWY 27 AT TWY B DID NOT CLEAR.
JA	OPERATIONS	Q	05:23	FDX1212 H/A306 SENT AROUND RWY 27. TRAFFIC CROSSING RWY 27 AT TWY B DID NOT CLEAR.
JA	OPERATIONS		05:59	COB

I certify that entries above are correct that all scheduled operations have been accomplished except as noted and that all abnormal occurrences and conditions have been recorded.

Signature(s) of watch supervisor(s):

ATTACHMENT

86

DAILY RECORD OF FACILITY OPERATION

Location MEM TOWER
Position ALL
Area MEM

Manager Mike Baker
Date 1/7/2010
Checked By:

Ini	Area	Type	Time	Remarks
JA	OPERATIONS		06:00	J SHORT ON RWY 36L C/R 27 WCLC
JA	OPERATIONS	Q	06:36	FDX1357 B757 WENT AROUND RWY 36L FLAP PROB: FM LANDED WCLC
SW	OPERATIONS		07:53	RWY 18L C/R 27 IN USE
JA	OPERATIONS		09:06	MONITORED POSITION RELIEF BRIEFING GC1
JA	OPERATIONS	Q	10:49	FDX1380 B727 SPENT AROUND RWY 27 TRAFFIC CROSSING RWY 27 AT TWY Y DID NOT CLEAR
CS	OPERATIONS		11:40	C. WILLS ON ABOVE NOTED
CS	OPERATIONS		13:20	WCLC
UA	OPERATIONS		16:30	RWY CLOSED BY OPS FOR ARRIVAL/DEPARTURES DUE TO ICE ON NORTH/SOUTH SIDE OF RWY. RWY 27/9 AVAILABLE FOR TAXI
UA	OPERATIONS	Q	16:43	ALERT 2 FDX461 A305, UNSPECIFIED HYDRAULIC ISSUES. FDX461 LANDED WCLC AT 1653 ALERT 51 CURED 1656Z
CB	OPERATIONS		19:34	C. BYRD ON
CB	OPERATIONS		19:53	WCLC
UA	OPERATIONS		23:04	RWY 27 AVAILABLE FOR ARR/DEP
CB	OPERATIONS		00:23	MONITORED POSITION RELIEF BRIEFING LC1
CB	OPERATIONS		00:35	MONITORED POSITION RELIEF BRIEFING LC2
CB	OPERATIONS	Q	01:29	ME S3122 ABORTED TAKEOFF RWY 36L DUE TO WARNING LIGHT. ACFT TAXIED BACK TO THE RAMP. ROC NOTIFIED
CB	OPERATIONS		02:13	C. CABANA ON
JA	OPERATIONS		04:00	J SHORT ON RWY 36L C/R 27.
JA	OPERATIONS	Q	04:33	FDX1337 B727 WENT AROUND RWY 27 UNSTABLE APPROACH WIND SHEAR
JA	OPERATIONS		05:59	QCR

I hereby certify that entries above are correct that all scheduled operations have been accomplished except as noted and that all abnormal occurrences and conditions have been recorded.
Signatories of watch supervisor(s):

DAILY RECORD OF FACILITY OPERATION

8C

Location: MEM TOWER
 Position: ATIS
 Area: MEM

Manager: Mike Baker
 Date: 1/19/2010
 Checked By: _____

Int	Area	Type	Time	Remarks
WR	OPERATIONS		06:00	T WEBER ON RWY 36 AND 3 IN USE
WR	OPERATIONS		06:58	RY 18 AND 27 IN USE
WR	OPERATIONS	Q	08:31	LATE ENTRY FROM PREVIOUS DAY FDX5031 MD11 COULD NOT EXIT RWY 27 CAUSING TWO GO AROUND FDX1253 AND FDX1202 TIME WAS 0510/18 JAN 2010
WR	OPERATIONS		10:40	MONITORED POSITION RELIEF BRIEFING
GC	OPERATIONS		11:52	G CLEARLY ON ABOVE NOTED
GC	OPERATIONS		12:00	RWY 18C/36C CLSD
GC	OPERATIONS		13:15	RWY 27 RE SD TO GC
GC	OPERATIONS		14:39	MONITORED POSITION RELIEF BRIEFING ON GC2
GC	OPERATIONS		16:50	MONITORED POSITION RELIEF BRIEFING ON GC1
CS	OPERATIONS		18:35	C WILLIS ON ABOVE NOTED
CS	OPERATIONS		19:02	RWY 18/R STAGGERED L/S IN USE
CS	OPERATIONS		19:40	WCLC
CS	OPERATIONS		19:45	RWY 18C/36C OPLN
CS	OPERATIONS		22:31	MONITORED POSITION RELIEF BRIEFING LC2
CS	OPERATIONS	Q	23:24	DAL1285, MD88 ON FINAL FOR RWY 18L, WAS SENT AROUND DUE TO ARRIVAL TRAFFIC INBOUND TO RWY 27 DURING CRDA.
CS	OPERATIONS		01:48	MONITORED POSITION RELIEF BRIEFING FD/CD
CS	OPERATIONS	Q	02:18	FLG3951 CRJ 2 ABORTED TAKE OFF RWY 18R DUE TO PASSENGER DOOR HANDLE CAUTION LIGHT DESTINATION OKC
CS	OPERATIONS		02:26	D SHAW ON ABOVE NOTED

I certify that entries above are correct that all scheduled operations have been accomplished except as noted and that all abnormal occurrences and conditions have been recorded. Signatures of watch supervisor(s)

FAA Form 7230-4 (Electronic Version)

DAILY RECORD OF FACILITY OPERATION

ATTACHMENT

9

Location: MEMPHIS
 Division: A-1
 Airport: MEM

Manager: Mike Baker
 Date: 12/15/2009
 Checked by: _____

Inr	Area	Type	Time	Remarks
050	OPERATIONS		06:00	G. CLIFARY ON, WCLC RWY 36L R AND 27 IN USE.
060	OPERATIONS		06:08	MONITORED POSITION RELIEF BRIEFING ON 060.
070	OPERATIONS		06:14	RWY 27 RELEASED TO 060.
080	OPERATIONS		11:51	C. BYRD ON.
090	OPERATIONS		11:00	WCLC
100	OPERATIONS		14:04	MONITORED POSITION RELIEF BRIEFING 100.
110	OPERATIONS	Q	15:16	ALERT 2, N4185X, P 52R, STATED THEY HAD A ROUGH RUNNING ENGINE AFTER CONTACTING DEPT. THE ACFT RETURNED AND LANDED RWY 36L WCLC AT 1516Z. ALERT SECURED.
120	OPERATIONS		18:00	RWY 27 IN USE.
130	OPERATIONS		16:07	MONITORED POSITION RELIEF BRIEFING 130.
140	OPERATIONS		18:18	C. WILLIS ON, ABOVE NOTED.
150	OPERATIONS		10:05	WCLC
160	OPERATIONS		11:25	MONITORED POSITION RELIEF BRIEFING 160.
170	OPERATIONS	Q	22:34	EXCESSIVE INVESTIGATED FOR POSSIBLE PILOT DEVIATION CROSSING RWY 27 AT NOVEMBER WITHOUT AUTHORIZATION. PILOT NOTIFIED VIA TOWER. ROD NOTIFIED.
180	OPERATIONS	Q	01:02	N185V, C172 EXECUTED A GO AROUND RWY 36L. PILOT REPORTED A SPEED CONTROL PROBLEM AS THE REASON FOR THE GO AROUND. N185V ENTERED TETC. CUSED TRAFFIC FOR RWY 36L AND LANDED WITHOUT INCIDENT.
190	OPERATIONS		02:10	MONITORED POSITION RELIEF BRIEFING 190/060.
200	OPERATIONS		02:21	J. COLYER ON, ABOVE NOTED.
210	OPERATIONS	E	02:30	OPERATING IN ESL MODE FOR STARS UPDATE.
220	OPERATIONS	E	03:15	STARS R/S.
230	OPERATIONS		04:00	G. CLIFARY ON, ABOVE NOTED RWY 36L R AND 27 IN USE.
240	OPERATIONS		04:52	MONITORED POSITION RELIEF BRIEFING ON 100.
250	OPERATIONS		05:10	00B

I certify that entries above are correct and that all scheduled operations have been accomplished except as noted and that all abnormal occurrences and operations have been recorded.

Signature(s) of watch supervisor(s):