THE SECRETARY OF TRANSPORTATION

WASHINGTON, D.C. 20590

December 29, 2008

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

Re: OSC File Nos DI-07-2793 and DI-07-2868

Dear Mr. Reukauf:

This letter responds to the Special Counsel's correspondence of December 20, 2007, regarding whistleblower concerns about the Federal Aviation Administration's (FAA) Certificate Management Office (CMO) for Southwest Airlines (SWA), located in Irving, TX. The whistleblowers, two Aviation Safety Inspectors within the CMO, alleged that FAA's Principal Maintenance Inspector (PMI) knowingly allowed SWA to operate aircraft in passenger revenue service in an unsafe or unairworthy condition, by overflying a critical inspection mandated by an Airworthiness Directive (AD)[1].

The whistleblowers, Charalambe "Bobby" Boutris and Douglas Peters, disclosed that they initially reported their concerns to FAA, which investigated the matter; however, they contended that FAA's investigation was incomplete, and they voiced concern that FAA did not take appropriate action to ensure SWA's future compliance with ADs and adherence to mandatory maintenance checks. The whistleblowers also expressed concern that FAA's ability to effectively fulfill its mission to promote aviation safety and enforce regulatory compliance was hampered by a less than appropriate arms-length relationship with the carrier.

I delegated responsibility for investigating the above matters to the Department's Inspector General, who has concluded his investigation and provided me the enclosed memorandum report presenting the results in this matter.

[1] Pursuant to 14 CFR Part 39, FAA issues Airworthiness Directives (ADs) to address unsafe conditions with aircraft, aircraft engines, propellers and appliances. Upon discovering an unsafe condition, FAA issues an AD and notifies the airlines of the existence of a known unsafe condition which is likely to exist or develop in other products of the same type design.

In short, the Office of Inspector General (OIG) found that an overly collaborative relationship between the air carrier and the PMI enabled the airline to violate FAA national policy and regulations regarding the maintenance of aircraft. Specifically, the OIG determined that the PMI knowingly allowed SWA to continue to operate 46 aircraft, carrying approximately 145,000 passengers, in an unsafe or unairworthy condition after the inspection date for an AD-mandated fuselage inspection had passed, without the required inspection. These 46 aircraft conducted 1,451 flights over an 8-day period before they were brought into compliance with the AD.

The PMI permitted, and encouraged, SWA to formally self-disclose the violation through its Voluntary Disclosure Reporting Program (VDRP), a partnership program with FAA which would allow the airline to avoid any penalties. SWA made the disclosure and indicated it had inspected or grounded all affected aircraft. In fact, the airline had not done so, continuing to operate the aircraft for 8 days after the carrier notified FAA.

Further, the OIG found that a Partial Program Manager (PPM), who was subordinate to the PMI, was aware the aircraft were not in a safe condition, but did not question the PMI, nor did he report the safety issue to other FAA managers. Finally, OIG determined that FAA officials in the Southwest Region failed to correct documented, long-standing systemic problems at SWA's Certificate Management Office, including lax enforcement, thus creating a serious lapse in regulatory oversight.

Based on the gravity of these findings, the Inspector General testified before the House Committee on Transportation and Infrastructure on April 3, 2008, and initiated an audit review of FAA oversight of airlines' regulatory partnership programs and FAA's national program for risk-based oversight, the Air Transportation Oversight System (ATOS). Also in April 2008, he testified before the Senate Committee on Commerce, Science, and Transportation, Subcommittee on Aviation Operations, Safety and Security; and the Senate Committee on Appropriations, Subcommittee on Transportation, Housing and Urban Development, and Related Agencies.

During the Inspector General's testimony, he made a series of recommendations to improve FAA's air carrier oversight practices, which were reiterated in OIG's *Review of FAA's Safety Oversight of Airlines and Use of Regulatory Partnership Programs* report. The Inspector General's recommendations were that FAA:

1. Implement and enforce a process for second-level supervisory review of decisions made by inspectors to accept or close voluntary self-disclosures in order to enhance oversight and accountability of the VDRP.

2. Ensure that inspectors conduct effective follow-up after accepting a self-disclosure, by verifying that air carriers take comprehensive corrective actions. Before accepting a new report of a previously disclosed violation, the inspector should evaluate whether the carrier has already developed and implemented a comprehensive solution.

3. Develop procedures for periodically rotating supervisory inspectors in order to promote objective air carrier oversight.

4. Issue post-employment guidance that includes a "cooling-off" period (e.g., 2 years) during which an FAA inspector who is hired at an air carrier he or she previously inspected is prohibited from acting in any type of liaison capacity between FAA and the carrier.

5. Revise its Customer Service Initiative and oversight mission statement to clearly identify the flying public as the primary stakeholder and beneficiary of its inspection efforts and clearly communicate this policy to all FAA inspection staff.

6. Devise a system for tracking and monitoring inspections that will alert local, regional and Headquarters management whenever an inspection is overdue so that immediate corrective action can be taken.

7. Create a national review team to conduct periodic quality assurance reviews of FAA's oversight of air carriers to ensure that (a) appropriate processes and procedures are being applied consistently and (b) pertinent policies, laws and regulations are being followed.

8. Establish an independent organization (that reports directly to the FAA Administrator or Deputy Administrator) to investigate safety issues identified by FAA employees.

With the support of Acting Administrator Sturgell, FAA concurred and has taken action to implement six of OIG's eight recommendations. However, FAA did not adopt the OIG's recommendation to periodically rotate supervisory inspectors, and it only partially adopted the OIG's recommendation to establish an independent investigative organization. The OIG has asked FAA to reconsider its response.

In addition to implementing the foregoing recommendations, FAA initiated a series of disciplinary actions for culpable employees. The nature and status of these actions is addressed in the attached OIG report.

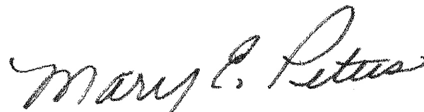
Moreover, on March 6, 2008, FAA initiated action to seek a $10.2 million civil penalty against Southwest for operating 46 airplanes without conducting the mandatory inspections for fuselage cracking. SWA declined to comply with the FAA-mandated August 29, 2008, deadline to pay the fine, and FAA and the airline are currently in informal negotiations. If the airline and FAA cannot reach an agreement, FAA can refer the matter to the U.S. Department of Justice, for further action.

The Inspector General and I have reviewed FAA's corrective actions to date on the six recommendations FAA agreed to implement and consider those actions to be responsive to OIG's recommendations pending completion. Nonetheless, because FAA did not satisfactorily carry out its previous oversight responsibilities, we will continue to follow-up with FAA on its actions to implement these recommendations.

I am grateful for the diligence of these dedicated employees in coming forward in the interest of improving aviation safety. I have established transportation safety as the Department's top strategic goal. To that end, I consider the actions of the PMI and PPM to be very serious, and am committed to ensuring that FAA effectively carries out its corrective action commitments in this important matter.

If you have any questions or require further information, please feel free to contact me or Acting Administrator Sturgell.

Sincerely yours,



Mary E. Peters

Enclosure

Memorandum

U.S. Department of Transportation

Office of the Secretary of Transportation

Office of Inspector General

Subject:	ACTION: Investigation of OSC Referral, Re: FAA Certificate Management Office for Southwest Airlines	Date:	December 23, 2008
From:	Calvin L. Scovel III Inspector General	Reply to Attn of:	
To:	The Secretary		

In accordance with statutory requirements of the U.S. Office of Special Counsel (OSC), this presents our investigative results regarding whistleblower concerns about the Federal Aviation Administration's (FAA) Certificate Management Office (CMO) for Southwest Airlines, located in Irving, TX. The whistleblowers, two Aviation Safety Inspectors within the CMO, alleged that FAA's Principal Maintenance Inspector (PMI) knowingly allowed SWA to operate aircraft in passenger revenue service in an unsafe or unairworthy condition, by overflying a critical inspection mandated by an Airworthiness Directive (AD)[1].

The whistleblowers, Charalambe "Bobby" Boutris and Douglas Peters, disclosed that they initially reported their concerns to FAA, which investigated the matter; however, they contended that FAA's investigation was incomplete, and they voiced concern that FAA did not take appropriate action to ensure SWA's future compliance with ADs and adherence to mandatory maintenance checks. The whistleblowers also expressed concern that FAA's ability to effectively fulfill its mission to promote aviation safety and enforce regulatory compliance took a "back seat to personal friendships and favors at the SWA CMO, compromising the safety of the flying public."

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[1] Pursuant to 14 CFR Part 39, FAA issues Airworthiness Directives (ADs) to address unsafe conditions with aircraft, aircraft engines, propellers and appliances. Upon discovering an unsafe condition, FAA issues an AD and notifies the airlines of the existence of a known unsafe condition which is likely to exist or develop in other products of the same type design. ADs specify inspections that must be carried out, conditions and limitations that must be complied with, and any actions that must be taken to resolve an unsafe condition. Although ADs are published in full in the Federal Register, they are incorporated by reference into the Code of Federal Regulations and bear the full effect of federal regulations.

The above allegations were referred to you by the U.S. Office of Special Counsel (OSC) on December 20, 2007. You delegated investigation of the allegations to our office. If you accept the results of our investigation, which comport with the requirements set forth at 5 USC §1213(d), we recommend that you transmit this report to OSC.

In addition to the OSC referral, at the request of the Chairman of the House Committee on Transportation and Infrastructure, we initiated an audit review of FAA's oversight of airline regulatory partnership programs and FAA's national program for risk-based oversight, the Air Transportation Oversight System (ATOS). The Chairman also requested that we determine whether FAA thoroughly investigated the complaints submitted by Mr. Boutris and Mr. Peters regarding FAA's oversight of SWA.

On April 3, 2008, we testified before the House Committee, and we subsequently testified before two Senate Subcommittees: on April 10, 2008, we testified before the Senate Committee on Commerce, Science, and Transportation, Subcommittee on Aviation Operations, Safety and Security; and on April 17, 2008, we testified before the Senate Committee on Appropriations, Subcommittee on Transportation, Housing and Urban Development, and Related Agencies. Our testimony included a series of recommendations to improve FAA's air carrier oversight practices, which we reiterated in our audit report, *Review of FAA's Safety Oversight of Airlines and Use of Regulatory Partnership Programs* report, released on June 30, 2008. [2]

Methodology

OIG investigative and audit staff traveled to Irving and Fort Worth, TX, on multiple occasions, to conduct interviews and review records at the SWA CMO, FAA's Southwest Region Division Office, and Southwest Airlines' Headquarters Office. We also interviewed senior FAA officials in Washington, DC, and Boeing engineering personnel at Boeing Headquarters in Seattle, WA.

In sum, we conducted nearly 30 interviews. Witnesses included inspectors, managers, engineers, and investigators. We also reviewed hundreds of records, including FAA Orders, FAA Reports of Investigation, inspection reports, other internal reports, maintenance logs, memoranda, emails, enforcement actions, proposed personnel actions, and related supporting documents.

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[2] A complete copy of this report is available at http://www.oig.dot.gov/item.jsp?id=2324.

Summary

In short, we found that an overly collaborative relationship between the air carrier and the PMI enabled the airline to violate FAA national policy and regulations regarding the maintenance of aircraft. Specifically, we determined that the PMI knowingly allowed SWA to continue to operate, in passenger revenue service, 46 aircraft, carrying an estimated 145,000 passengers, in an unsafe or unairworthy condition after the inspection date for an AD-mandated fuselage inspection had passed, without the required check. The PMI permitted—and encouraged—SWA to formally self-disclose the violation through its Voluntary Disclosure Reporting Program (VDRP), a partnership program with FAA which would allow the airline to avoid any penalties. SWA made the disclosure, and indicated that it came into compliance with the AD, meaning it had inspected or grounded all affected aircraft. In fact, the airline had not done so, continuing to operate the aircraft for 8 days after the carrier had notified FAA. Under 14 CFR Part 39, the aircraft were considered unairworthy and were required to be grounded until the inspections could occur.

We further found that an FAA Partial Program Manager (PPM), who was subordinate to the PMI, was aware the aircraft were not in a safe condition, but did not question the PMI as to why he did not require SWA to ground the aircraft, nor did he report the safety issue to other FAA managers.

Additionally, we determined that FAA officials in the Southwest Region failed to correct documented, long-standing systemic problems at the SWA CMO, thus creating a serious lapse in regulatory oversight, and needlessly placing the flying public at risk. For example, problems were identified to FAA Southwest Region management officials as early as Fall 2005, when a peer inspection identified a pattern of lax enforcement by the PMI. These FAA officials failed to remedy the situation or take action against the PMI.

Based on our findings, we recommended to FAA that it implement a series of management controls to strengthen CMO oversight of carriers nationwide and preclude recurrence of the kind of improprieties that occurred in this matter. Our eight recommendations to FAA included implementing controls over the VDRP process, such as implementation of a second-level review of decisions made by inspectors to accept or close voluntary self-disclosures, and that inspectors conduct effective follow-up of self-disclosures by verifying that air carriers take comprehensive corrective actions, and controls regarding FAA's risk-based ATOS program. We also recommended that FAA devise a system for tracking and monitoring inspections that will alert local, regional and Headquarters management whenever an inspection is overdue; and that FAA create a national review team to conduct periodic quality assurance reviews of FAA's oversight of air carriers.

With the support of Acting Administrator Sturgell, FAA concurred with, and has taken action to implement six of our eight recommendations. We have reviewed FAA's corrective actions on the six recommendations to date and consider them to be responsive to our findings and recommendations pending completion. However, FAA disagreed with one recommendation, and proposed an inadequate alternative to implement a second recommendation. We believe both recommendations are fundamental to improving FAA's air carrier oversight: (1) that FAA periodically rotate supervisory inspectors, or identify an alternative method to ensure reliable and objective air carrier oversight, and (2) that FAA establish an independent organization to investigate safety issues identified by FAA employees. Although we have asked FAA to reconsider its response to these two recommendations, we recognize that responsibility for reaching a final decision will likely rest with the new FAA Administrator upon assumption of office.

In addition to implementing most of the recommendations contained in our audit report, FAA proposed disciplinary actions for the PMI and the PPM based on their culpability. The PMI retired prior to receiving a Notice of Proposed Removal, and the PPM retired a month after receiving a Notice of Proposed Removal. In addition, FAA issued administrative action notices to the Southwest Region Division Manager and Assistant Division Manager on September 12, 2008, the disposition of which remains pending.

Moreover, on March 6, 2008, FAA initiated action seeking a $10.2 million civil penalty against Southwest for operating 46 airplanes without conducting the mandatory inspections for fuselage cracking. SWA declined to comply with the FAA-mandated August 29, 2008, deadline to pay the fine, and FAA and the airline are currently in informal negotiations. If the airline and FAA cannot reach an agreement, FAA can refer the matter to the U.S. Department of Justice for further action.

Details

A. Overflight of Airworthiness Directive 2004-18-06

SWA filed self-disclosure, then continued operating the aircraft

On March 14, 2007, while reviewing AD compliance records, SWA discovered it was in violation of AD 2004-18-06.[3] AD 2004-18-06 requires airlines to inspect certain upper and lower skin panels on the fuselage of Boeing 737s (series 200, 300, 400 and

[3] SWA initiated the AD compliance review after learning that Mr. Boutris intended to conduct a similar review in the near future.

500) for fatigue cracking.[4] Pursuant to the AD, each Boeing 737 must be inspected for fuselage cracks every 4,500 cycles, after the aircraft reaches 35,000 cycles.[5] If left unrepaired, fuselage cracks can lead to separation of the fuselage and rapid decompression of the cabin.

Upon discovering the AD violation, SWA reported it to the PMI the following day. FAA requires air carriers to ground non-compliant aircraft and FAA inspectors to ensure that carriers comply; however, in this instance the PMI did not direct SWA to ground the 47 affected aircraft[6] as required. Instead, the PMI encouraged SWA to formally self-disclose the violation through FAA's Voluntary Disclosure Reporting Program (VDRP), which would absolve the carrier of any penalties. SWA then self-disclosed the AD violation, and the PMI accepted the self-disclosure on March 19, 2007.

Once it formally self-disclosed the violation, SWA represented to FAA that it was in compliance with the AD, i.e., that it had inspected or grounded all affected aircraft. However, we found that, to the contrary, SWA continued to operate the non-compliant aircraft in violation of 14 C.F.R. § 39.7. In fact, we determined that, during those eight days, several of the affected aircraft landed in airports with inspection and repair facilities, yet SWA continued to delay the inspections. We found that between March 15, 2007, and March 23, 2007, SWA flew 1,451 flights, carrying an estimated 145,000 passengers, on 46 non-compliant Boeing 737s.

On March 22, 2007, Mr. Boutris, the first whistleblower, was conducting routine surveillance at Chicago's Midway Airport when he observed SWA personnel repairing a cracked fuselage on a Boeing 737, even though SWA had previously indicated on its self-disclosure that it had already inspected or grounded all affected aircraft. Mr. Boutris confirmed that the aircraft he observed under repair was covered by the AD, and consequently, should have been grounded days earlier. Mr. Boutris then reported the incident to the SWA CMO Manager. The SWA CMO Manager responded by directing a review of records for all other SWA Boeing 737s covered by the AD, to ascertain the full extent of SWA's non-compliance.

In the course of reviewing these records, Mr. Peters, the second whistleblower, determined that SWA had continued to operate a total of 47 Boeing 737s that were covered by the AD, but had not yet been inspected for fuselage cracks. During

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[4] FAA issued AD 2004-18-06 in response to a fatal accident that occurred in 1988, when an Aloha Airlines Boeing 737 lost a major portion of its hull in-flight due to fatigue cracks on its fuselage, resulting in one fatality and multiple injuries.

[5] A cycle is equivalent to one take-off and landing.

[6] SWA initially determined that 47 Boeing 737 aircraft had over flown the AD; however, it later determined the number was only 46.

inspections conducted from March 15, 2007, to March 23, 2007, SWA maintenance personnel discovered fatigue cracks on the fuselages of four other Boeing 737s. Had Mr. Boutris not observed SWA maintenance staff at Midway Airport repairing cracks on the first Boeing 737, SWA might have continued to operate the other four Boeing 737s in an unairworthy condition for an indefinite period of time, possibly with catastrophic consequences.

The PMI and PPM failed to enforce the AD and ground the aircraft

FAA inspectors are required to ground all aircraft deemed unsafe or non-compliant. FAA Order 8300.10 CHG 7 describes an inspector's duties in this regard as follows:

> An inspector who becomes aware of an unsafe condition in an aircraft that is being operated or about to be operated and fails to act . . . is in dereliction of duty. This duty is placed specifically by Congress upon the inspector rather than on the Administrator. If the inspector, after due consideration, still has any doubts regarding whether or not to ground the aircraft, the grounding notice should be issued.

The two whistleblowers maintained that the PMI knowingly permitted SWA to continue flying non-compliant aircraft after he accepted SWA's self-disclosure. Two SWA officials corroborated this information by relating that the PMI verbally granted them permission to continue flying the aircraft. In a written statement to FAA, the PMI admitted, "I should have grounded the affected aircraft and informed [regional management] for further guidance. I permitted unairworthy SWA aircraft to operate in revenue service and I was wrong to do so. However, politically, I felt that grounding the SWA aircraft would have negative consequences for the FAA."

Similarly, we also found that the SWA Boeing 737-300/500 Partial Program Manager (PPM), a subordinate to the PMI, was likewise aware of the unsafe condition, yet he too failed to take action. In spite of the serious safety ramifications presented by the overflight, the PPM did not inquire into the matter further, he did not consult with the CMO Manager or any other FAA official in the regional office or FAA Headquarters, and he did not advise the airline that it had the option of pursuing an Alternate Means of Compliance (AMOC).[7] When interviewed, the PPM was adamant that the aircraft did not need to be grounded. He insisted that the situation did not pose a legitimate safety concern; therefore, an AMOC was not warranted. He argued, "None of [the airplanes] blew their top did they? They didn't kill anybody did they? If you think a two-inch crack is going to bring that airplane down then you're sadly mistaken."

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[7] An AMOC is an alternate approach or solution for resolving an airworthiness deficiency in lieu of the approach specified in an AD. Prior to implementing an AMOC to satisfy an AD, an airline must obtain approval from the airplane manufacturer (in this case, Boeing) and from FAA's Aircraft Certification Branch.

Given the evidence presented above, we determined that the PMI and PPM knowingly allowed SWA to operate aircraft in passenger revenue service in an unsafe or unairworthy condition, in violation of FAA Order 8300.10 CHG 7 and 14 C.F.R. 39. The PMI and the PPM bore ultimate responsibility for overseeing the maintenance program for the SWA Certificate 737-300/500 fleet, yet neither of them offered instructions, guidance, or oversight to assist SWA in taking remedial action. Therefore, the evidence reflects that the PMI and the PPM were derelict in the performance of their duties.

FAA failed to conduct adequate follow-up

We found that, after the AD overflight was discovered, FAA failed to conduct sufficient follow-up to ensure that SWA implemented appropriate remedial action. FAA did not ask SWA for a list of the tail numbers of affected aircraft until November 2007, after Congressional staff began looking into the whistleblower allegations, and eight months after the PMI accepted the event into the VDRP. Before FAA accepts a self-disclosed event into the VDRP, it is required to verify that the airline has taken appropriate corrective actions. Without the tail numbers, it would have been impossible for FAA to ascertain whether SWA had in fact reported all affected aircraft and brought all affected aircraft into compliance with the AD. Nevertheless, the PMI accepted the self-disclosure and proceeded to close the matter a few weeks later, without ever obtaining this crucial information.

In an attempt to remedy any outstanding issues and forestall future AD violations, SWA proposed a comprehensive fix. In the self-disclosure, SWA reported that "all AD compliance personnel have been counseled on the importance of performing adequate reviews of AD documents." SWA also indicated that it planned to add another employee to the AD compliance group. In April 2007, the PMI accepted SWA's proposed solution but did not indicate that he had actually reviewed the solution before accepting it. In our opinion, the PMI should not have accepted SWA's proposed comprehensive fix, as it was inadequate to effectively resolve the root cause of the AD overflight.

In an internal follow-up audit, SWA asserted that the comprehensive fix "had proven" to be effective in preventing recurrence and FAA accepted this assertion. Nevertheless, we found that, to the contrary, the March 2007 overflight of AD 2004-18-06 was by no means an isolated incident, and additional AD violations did in fact occur after SWA implemented the comprehensive fix. For example, we found that three more SWA aircraft overflew AD 2004-18-06 on February 22, 2008, and a fourth did so on March 12, 2008, when SWA maintenance staff neglected to perform timely fuselage inspections. In addition, on March 12, 2008, 38 SWA aircraft overflew a different AD when SWA failed to perform required inspections. SWA only discovered these AD violations after we asked them to validate data they previously

provided to us. Had FAA undertaken adequate follow-up measures and validated the data itself, it would have uncovered the AD violations more than 18 months earlier.

FAA also initiated a series of internal reviews regarding the overflight of AD 2004-18-06. As early as April 2007, FAA concluded that the PMI had been complicit in allowing SWA to continue flying aircraft in violation of the AD. Yet, FAA did not attempt to determine the root cause of the safety issue, take meaningful action against the PMI, or pursue enforcement action against SWA until November 2007, when Congressional staff began looking into the whistleblower allegations. Senior FAA officials contended they were precluded from taking action until FAA Security completed its investigation. However, our investigation revealed that FAA Security provided Southwest Region officials a copy of its initial investigative report in July 2007.[8]

B. Longstanding, Systemic Problems at the SWA CMO

We found that the March 2007 AD overflight could be attributed to, and was indicative of, longstanding, systemic management and operational problems at the SWA CMO, which were identified to FAA Southwest Region management officials as early as September 2005.

Misuse of the Voluntary Disclosure Reporting Program

We found that the PMI's pattern of lax enforcement was especially apparent in the continued misuse of the VDRP. Under the terms of the VDRP, air carriers are only permitted to self-disclose violations discovered by their own employees, not those discovered by FAA inspectors. However, several witnesses alleged that the PMI routinely allowed SWA to self-disclose AD violations, including ones that a CMO inspector uncovered. We also found that, on multiple occasions, the PMI allowed SWA to self-disclose AD violations through the VDRP, even though the airline had not yet developed a comprehensive solution for the reported safety deficiencies. Proposing a comprehensive solution is a mandatory prerequisite for filing a self-disclosure through VDRP.

Additionally, we found that the PMI allowed false information to remain in the VDRP database on several occasions. As discussed above, in March 2007, the PMI allowed information to be entered into the VDRP indicating that SWA had inspected or grounded all aircraft covered by AD 2004-1806, even though he knew that SWA continued to operate non-compliant aircraft. In addition, we discovered that, around

[8] After reviewing the initial report of investigation, Southwest Region officials directed FAA Security to conduct further investigation. FAA Security submitted a supplemental Report of Investigation in October 2007.

the same time, SWA similarly misrepresented information in VDRP in connection with another series of missed inspections. The whistleblowers alleged that, in April 2007, Mr. Peters discovered that SWA self-disclosed that it had missed maintenance inspections on the Standby Rudder Power Control Unit Hydraulic System Internal Leakage Check on 70 aircraft. Although the PMI granted SWA permission to continue operating the aircraft in passenger revenue service for an additional 14 days, we found that the VDRP database falsely indicated that the non-compliance ceased upon detection.[9]

We believe that the VDRP and other partnership programs, when properly implemented, can be valuable safety tools. However, the success of these programs is largely dependent upon the integrity of the individuals utilizing them. We concluded that, at the SWA CMO, the effectiveness of the VDRP program was compromised by FAA personnel pursuing collaboration and partnership at the expense of oversight and enforcement.

Overly collaborative relationship between FAA and SWA

Our investigation uncovered longstanding, systemic problems at the SWA CMO. We found that the PMI and CMO inspectors developed an inappropriately collaborative relationship with SWA employees. In particular, we found that CMO inspectors often collaborated with SWA's regulatory compliance manager, who had previously been employed by FAA as an inspector assigned to the SWA CMO and had reported directly to the PMI. We found that this individual transitioned from being an FAA inspector to an SWA compliance manager in just two weeks.

According to the whistleblowers, extreme favoritism that the PMI displayed toward SWA caused an internal rift among the office staff. The conflict and tension between the two camps eventually became so severe that it adversely affected inspectors' abilities to perform their jobs.

In July 2005, the SWA CMO Manager raised this issue with SWA Regional officials, warning them that the PMI and other FAA inspectors had "relax[ed] into a level of coziness with Southwest," that contributed to poor enforcement and inadequate follow-up. Other CMO employees made similar complaints to the Regional Office in September 2005, alleging that the PMI collaborated too closely with SWA employees and failed to comply with national and regional enforcement policies. However, we found that FAA's Southwest Region management officials believed these issues to be personality-driven and failed to recognize the significance such division was creating.

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[8] We note that the Standby Rudder Power Control Unit Hydraulic System Internal Leakage Check inspections were not mandated by an AD. Therefore, in this instance, the PMI's decision not to immediately ground the 70 aircraft did not violate 14 C.F.R. 39 or FAA Order 8300.10.

FAA repeatedly failed to take timely corrective action

Prior to the March 2007 allegations regarding the overflight of AD 2004-18-06, FAA had previously conducted multiple investigations into various deficiencies at the SWA CMO. Nevertheless, we found that FAA had repeatedly failed to adequately address the systemic problems their investigations disclosed.

For example, in October 2005, the Southwest Region Division Manager organized a Peer Review Team, comprised of other CMO managers within the Southwest region, to address complaints that the PMI engaged in a pattern of lax enforcement. Among its findings, the team reported that the PMI did not always follow FAA enforcement procedures. The team also encountered a perception among FAA inspectors that the PMI showed favoritism towards the carrier. After reviewing 29 Letters of Concern that the CMO had issued to SWA, the team determined that five could have been prepared as Letters of Investigation instead.[10] In response to the team's findings, Southwest Region management officials merely directed the SWA CMO Manager and the PMI to participate in mediation; it did not take any measures to remedy the PMI's lax enforcement.

In November 2005, the SWA CMO Manager again requested assistance from the Southwest Region Division Manager to investigate how the PMI performed his safety oversight duties for SWA. The SWA CMO Manager identified three areas of concern and suggested that the PMI's actions may present a safety risk. He requested management assistance in conducting an in-depth evaluation of his concerns. However, we found no evidence that any response was made by any regional official to the SWA CMO Manager, nor evidence that his concerns were elevated to FAA officials outside the region – either by the SWA CMO manager, or by members of the Southwest Region management team.

In June 2006, Southwest Region management officials requested a Work Environment Advisory Team (WEAT) review of the SWA CMO. The report issued in response to that review indicated a continuing tense relationship between the SWA CMO Manager and the PMI, as well as issues between the PMI and the Principal Avionics Inspector (PAI) for SWA. The WEAT team recommended that the SWA CMO management team be placed on official notice that workplace conflicts were unacceptable, and that the management team engage in team-building exercises.

[10] Letters of Investigation present more serious consequences than Letters of Concern, as they may involve legal enforcement action.

We believe that the numerous allegations, investigations and reports involving the SWA CMO should have put the Southwest Region management officials on notice of a potential serious safety risk in that office. FAA management did not investigate the underlying allegation that the PMI had developed an overly collaborative relationship with the carrier. Had FAA officials taken timely, comprehensive action to address the allegations of an overly collaborative relationship between the carrier and the PMI, they may have realized that PMI's overly collaborative relationship with SWA was adversely affecting safety oversight.

Multiple missed ATOS inspections

We also determined that the chronic maintenance issues plaguing the SWA CMO went undetected for so long in part due to FAA oversight lapses at the regional and national levels. Specifically, FAA did not ensure that its inspectors at the SWA CMO carried out critical safety inspections required by FAA's Air Transportation Oversight System (ATOS). ATOS inspectors are expected to evaluate an air carrier's systems for monitoring AD compliance every five years; yet we found that FAA inspectors had not evaluated SWA's AD compliance system since 1999. We note that at the time of the SWA disclosure (March 15, 2007), 21 key maintenance-related ATOS inspections had been overdue for at least five years at the SWA CMO.

FAA's Customer Service Initiative compromised safety oversight

Finally, it appears that FAA management fostered a culture whereby air carriers, including SWA, were considered the primary customer of its oversight mission instead of the flying public. Satisfying customer requirements is a key tenet of the ISO 9001 Quality Standards.[11] To meet this requirement, FAA announced its Customer Service Initiative in 2003, which defined its customers as the people and companies requesting FAA certification, other aviation services, or information related to the products and mission of the FAA. The initiative, however, was geared toward airlines, repair stations, and other commercial operators–not the flying public. The SWA case appears to illustrate that FAA's definition of its customer had a pervasively negative, although unintended, impact on its oversight program in the Southwest region.

[11] ISO 9000 is a family of standards for quality management designed to implement international standards for business, government, and society. It is maintained by the International Organization for Standardization and is administered by accreditation and certification bodies. Some of the requirements in ISO 9001 (which is one of the standards in the ISO 9000 family) include a set of procedures that cover all key processes in the business; monitoring processes to ensure they are effective; keeping adequate records; checking output for defects, with appropriate and corrective action where necessary; regularly reviewing individual processes and the quality system itself for effectiveness; and facilitating continual improvement.

Recommendations and Corrective Actions

During our Congressional testimony, and as addressed in our subsequent June 30, 2008 report: *Review of FAA's Safety Oversight of Airlines and Use of Regulatory Partnership Programs*, we recommended to FAA that it:

1. Implement and enforce a process for second-level supervisory review of decisions made by inspectors to accept or close voluntary self-disclosures in order to enhance oversight and accountability of the VDRP.

2. Ensure that inspectors conduct effective follow-up after accepting a self-disclosure, by verifying that air carriers take comprehensive corrective actions. Before accepting a new report of a previously disclosed violation, the inspector should evaluate whether the carrier has already developed and implemented a comprehensive solution.

3. Develop procedures for periodically rotating supervisory inspectors in order to promote objective air carrier oversight.

4. Issue post-employment guidance that includes a "cooling-off" period (e.g., two years) during which an FAA inspector who is hired at an air carrier he or she previously inspected is prohibited from acting in any type of liaison capacity between FAA and the carrier.

5. Revise its Customer Service Initiative and oversight mission statement to clearly identify the flying public as the primary stakeholder and beneficiary of its inspection efforts and clearly communicate this policy to all FAA inspection staff.

6. Devise a system for tracking and monitoring inspections that will alert local, regional and Headquarters management whenever an inspection is overdue so that immediate corrective action can be taken.

7. Create a national review team to conduct periodic quality assurance reviews of FAA's oversight of air carriers to ensure that (a) appropriate processes and procedures are being applied consistently and (b) pertinent policies, laws and regulations are being followed.

8. Establish an independent organization (that reports directly to the FAA Administrator or Deputy Administrator) to investigate safety issues identified by FAA employees.

With the support of Acting Administrator Sturgell, FAA agreed to fully implement six of our eight recommendations. We have reviewed FAA's corrective actions to date on the six recommendations they agreed to implement, and consider them to be responsive to our recommendations pending their completion. Nonetheless, because FAA did not satisfactorily carry out its previous oversight responsibilities, we will continue to follow-up with FAA on its actions to implement these recommendations. As with our recent DFW TRACON investigation (also a whistleblower case), the long-term effectiveness of FAA's corrective actions in this matter can only be achieved with the strong commitment and follow-through of FAA's leadership.

FAA did not adopt our recommendation to take steps to ensure the independence of supervisory inspectors by periodically rotating these individuals because of the costs involved, and it only partially adopted our recommendation to establish an independent investigative organization by creating a new database called the Safety Issue Report System (SIRS), which allows Aviation Safety Inspectors to elevate safety issues to FAA Headquarters when these issues are not satisfactorily resolved at the local level.

We believe FAA should consider alternatives to comply with the intent of our recommendation to periodically rotate supervisory inspectors. We recognize that it may be costly to move supervisory inspectors on a periodic basis; however, we continue to believe that FAA needs a process to ensure objective air carrier oversight by its inspectors. FAA should propose an alternative to accomplish this. For example, FAA could use the Independent Review Team, established as a result of the earlier Congressional hearings on this matter, to independently review and periodically assess the independence of FAA's supervisory inspectors.

Moreover, we did not consider FAA's action to implement SIRS to be responsive to our recommendation to establish an independent investigative organization. We believe FAA's response was inadequate to correct the problems we identified, and we requested that FAA reassess its response. In just this past week, FAA's Acting Administrator advised us that FAA is creating an independent organization, which coordinates through FAA's Office of Chief Counsel, to independently evaluate the quality of investigations conducted by FAA's lines of business in response to referrals from external sources such as OIG, OSC, and GAO, as well as managing the referrals received from various FAA hotlines and the SIRS reporting system.

We also do not consider this action to be adequate. We have been told by FAA the group will not be staffed by people with the technical knowledge, skills, and ability to appropriately determine the sufficiency of a safety investigation. Therefore, we question how such a group, without either the investigative authority, or the technical ability, will they be able to independently validate investigative findings and conclusions.

Although we have asked FAA to reconsider its response to these recommendations, at this point in time, responsibility for reaching a final decision will likely rest with the new FAA Administrator upon assumption of office. Accordingly, we reiterate the recommendation from our testimonies and audit report that FAA: (1) take steps to ensure the independence of supervisory inspectors; and (2) establish an independent organization, staffed with technical experts, to investigate employee safety concerns about FAA's Flight Standards and Aircraft Certification directorates, similar to the Air Traffic Safety Oversight Service (AOV), which independently audits and investigates FAA's Air Traffic Organization.

In addition to implementing the above-referenced recommendations, FAA initiated a series of administrative actions for culpable employees, summarized as follows:

- FAA prepared, and was planning to issue, a Notice of Proposed Removal to the PMI. However, the PMI retired on June 19, 2008, just days before FAA intended to issue him the letter. As such, pursuant to FAA Human Resource requirements, a copy of the Notice of Proposed Removal was not included in his Official Personnel File.

- FAA issued a Notice of Proposed Removal to the PPM on July 31, 2008. He subsequently retired on August 29, 2008.

- FAA issued Notices of Proposed Administrative Action to the Southwest Region Division Manager and Assistant Division Manager on September 12, 2008. FAA has not yet taken final action in respect to these officials.

Moreover, on March 6, 2008, FAA initiated action to seek a $10.2 million civil penalty against SWA for operating 46 airplanes without conducting the mandatory inspections for fuselage cracking. SWA declined to comply with the FAA-mandated August 29, 2008 deadline to pay the fine, and FAA and the airline are currently in informal negotiations. If the airline and FAA can not reach an agreement, FAA can refer the matter to the U.S. Department of Justice for further action.

If I can answer any questions, please contact me at x61959, or my Deputy, Theodore Alves, at x66767.