

U.S. Department of Transportation

Office of the Secretary of Transportation

April 30, 2009

Office of Inspector General Washington, DC 20590

Catherine McMullen, Esq. Chief, Disclosure Unit U.S. Office of Special Counsel 1730 M Street, N.W., Suite 300 Washington, D.C. 20036-4505

Re: OSC File Nos. DI-07-2793 & DI-07-2868

Dear Ms. McMullen:

Pursuant to your email request of February 26, 2009, and our discussions of March 20, 2009, and April 23, 2009, the following supplemental information is presented by topical area:

OIG Audit report

In regards to the footnote in our December 23, 2008, report referencing our audit report titled, *Review of FAA's Oversight of Airlines and Use of Regulatory Partnership Programs*, we consider the audit report to be part of our response. Our intent was to address the allegation contained in Section II – *Information Disclosed* of OSC's December 20, 2007, referral that, "the Supervisory Principal Maintenance Inspector...and others, violated FAA national policy and regulations...[which] resulted in chronic system and repetitive non-compliance maintenance issues." Our audit report is included in this Supplemental Report as **Exhibit 1**.

Violations

Section 1213(d) of Title 5 requires that the report from the head of the agency list "any violation or apparent violation of law, rule, or regulation." Based on our

factual findings, the December 23, 2008, report transmitted by the Secretary concluded that Mr. Gawadzinski and Mr. Collamore violated FAA Order 8300.10 and 14 C.F.R. § 39 by knowingly allowing SWA to operate aircraft in passenger revenue service in an unsafe or unairworthy condition.

Standby rudder power control unit hydraulic system internal leakage check

The OSC referral, p. 5, Standby Rudder Power Control Unit Hydraulic System Internal Leakage Check, referred information that "FAA officials falsely reported in the VDRP report that non-compliance with a required maintenance check had ceased after detection, when it had not; and 2) that there was no follow-up by FAA to ensure tracking and completion of the corrective actions, as mandated by the Quality Procedures Manual."

In our report to Secretary Peters, dated December 23, 2008, we concluded the Principal Maintenance Inspector (PMI Gawadzinski) improperly granted SWA permission to continue to operate the aircraft in passenger revenue service for an additional 14 days, although the VDRP database—which is populated by SWA personnel—falsely indicated that the non-compliance ceased after detection. We also noted that the checks were not mandated by an Airworthiness Directive; therefore, Mr. Gawadzinski's decision not to ground the 70 aircraft did not violate 14 CFR 39. Given OSC's questions, a more detailed discussion of this matter is provided as follows:

On March 19, 2007, Southwest disclosed to FAA, via FAA's Voluntary Disclosure Reporting Program (VDRP), that 70 aircraft overflew an ongoing maintenance task from Southwest's Maintenance Procedure Manual. The task was an internal leak check (of hydraulic fluid) of the standby rudder power control unit (PCU). The check should have been done every 12,500 hours. According to Mr. Boutris, the overfly went undetected for at least one year. Later analysis performed by FAA showed it was overflown by 1,413 flights on the 70 affected aircraft.

We concluded that the overfly occurred due to a lack of attention to detail by Southwest Airlines employees when transferring key information from one task card to another, similar to the cause of the AD overfly previously addressed in our December 23, 2008, report to then-Secretary Peters which was previously transmitted to OSC. Southwest was attempting to lengthen the time interval

between maintenance tasks, called an 'escalation,' and it failed to note that this task was required every 12,500 hours.

According to Mr. Boutris, the overfly occurred on the aircraft he was charged with overseeing; however, Mr. Gawadzinski withheld the information from Mr. Boutris and worked the issue himself as part of the VDRP.

According to multiple FAA managers we interviewed at FAA's Southwest Region headquarters as well as the SWA CMO (Mr. Stuckey, Mr. McGarry, Mr. Lambert, and Mr. Mills), Mr. Gawadzinski did not attempt to verify that Southwest had identified the entire population of aircraft affected by the rudder overfly. FAA, vis-à-vis Mr. Gawadzinski, took Southwest's word at face value. Southwest's "comprehensive fix" was accepted by Mr. Gawadzinski on April 10, 2007, and closed with a Letter of Correction, signed by Mr. Gawadzinski. We note that this was the same date that the fuselage crack AD was officially disclosed to FAA as well (also via the VDRP). Moreover, this disclosure involved the same two individuals as the fuselage AD: Mr. Comeau for Southwest Airlines, and Mr. Gawadzinski for FAA.

The VDRP database self-disclosure entries were made by SWA personnel. In this instance, the carrier indicated that the non-compliance had ceased after they detected it. This was not accurate, and Mr. Gawadzinski was aware that the non-compliance had, in fact, not ceased. In his sworn statement to FAA Security Investigator Jay LaFlair, Mr. Gawadzinski stated that he did not ground the aircraft because:

"[I]t was not an AD violation. This issue was an overflight of inspections on Standby Rudder PCU which is part of the Approved Maintenance Program for SWA... Based on the VDRP information and my contact with [Paul] Comeau, I considered these affect[ed] aircraft to be unairworthy; however I did not ground the aircraft and allowed them to remain in revenue service because the rudder issues involved a secondary system. Also SWA was taking appropriate action and actually accomplished all inspections in seven days with no discrepancies noted."

Once an overflight is identified in the VDRP, the non-compliance is required to be corrected. Typically, this is done by grounding the aircraft until the maintenance task can be performed. 14 CFR 121.153 prohibits air carriers from operating aircraft that are considered unairworthy. Despite considering the aircraft unairworthy, and knowledge that Federal Aviation Regulations require all aircraft carrying revenue paying passengers to be airworthy, Mr. Gawadzinski nevertheless granted SWA permission to continue to operate the aircraft in passenger revenue service for an additional 14 days before all 70 aircraft were brought into compliance.

In late April 2007, after being made aware of SWA's potential improper disclosure via the VDRP, Mr. Mills directed Paul Cotti, SWA CMO's Geographic Unit Supervisor, to review SWA's VDRP report and comprehensive corrective actions. Mr. Cotti concluded that SWA's written explanation did not address safety concerns, nor did the disclosure contain justification to continue operating without performing the inspections. Mr. Cotti indicated that the disclosure, which contained both SWA's report and Mr. Gawadzinksi's review, not only lacked supporting documentation, it failed to identify a single tail number of the affected aircraft. Therefore, Mr. Cotti could not conclude that all affected aircraft had been properly identified and inspected.

It was not until November 2007 that FAA Southwest Region officials directed a subsequent review of the disclosure, performed by Eddie Mars, the PMI for the Dallas Fort Worth FSDO. Mr. Mars' review verified that SWA had correctly identified and inspected all potentially affected aircraft, and that all 70 aircraft had been brought into compliance by March 31, 2007.

In 2008, FAA initiated an enforcement action against SWA regarding the rudder leak check overflight; however, the matter was consolidated with several other pending enforcement actions, including the AD overflight issue, in a 2009 settlement agreement. In March 2009, SWA paid a \$7.5 million fine as part of the settlement agreement.

<u>Inappropriate communications between SWA CMO and Southwest Airlines regulatory compliance personnel</u>

OSC referred allegations that in June 2007, Mr. Peters reported his concerns regarding inappropriate communications between SWA CMO inspectors and Southwest Airlines Regulatory Compliance Department personnel to Robert Naccache, the SWA CMO Assistant Manager.

Specifically, Mr. Peters asserted that SWA CMO inspectors inappropriately shared information with Southwest Airlines Regulatory Compliance personnel regarding his access to Southwest Airlines maintenance records. Mr. Peters stated that two inspectors (John Bassler and Sanford Stennis) admitted to Robert Naccache, then-SWA CMO Assistant Manager, that they had shared such information with SWA. Mr. Peters believed this was indicative of the inappropriate relationships between FAA Airworthiness inspectors and the airline.

Our April 3, 2008, testimony; June 30, 2008, audit report; and December 23, 2008, investigative report concluded that there was an overly collaborative and therefore inappropriate relationship between the SWA CMO and the carrier. The records Mr. Peters was accessing belonged to Southwest Airlines (Imagio is the internet-based program which inspectors from the SWA CMO use to access SWA's maintenance records.)

Mr. Bassler told FAA Security that he did not access the records; rather, he was attending a meeting at SWA when an SWA employee showed a report to Mr. Gawadzinski, in Mr. Bassler's presence. This data report indicated that Mr. Peters had accessed SWA records, via Imagio, over 40 times, and that Mr. Boutris had accessed SWA's maintenance records four times. As the maintenance data contained and accessible via Imagio belonged to SWA, and Mr. Bassler did not access the data; we did not find a violation of an FAA Order, nor did we find that an improper release of data occurred. However, as we have previously reported, we found that an overly friendly relationship between the carrier and the CMO existed. SWA's discussion with Mr. Gawadzinski regarding to another inspector's activities was reflective of the inappropriate relationship which had developed between Mr. Gawadzinksi and SWA.

When interviewed by FAA Security regarding knowledge of Mr. Gawadzinski's relationship with SWA, Mr. Bassler told Mr. Lambert and Special Agent Jay LaFlair that he was angry at Mr. Peters for continuing to perform Mr. Mills' data request despite Mr. Mills' removal as manager of the office. Mr. Bassler, who had

been waiting for 14 days for Mr. Peters to provide some information for one of Mr. Bassler's work projects, believed that Mr. Peters should have been working on his request instead of Mr. Mills'.

Mr. Peters and Mr. Bassler confirmed to Special Agent LaFlair that they discussed this issue with Robert Naccache, the SWA CMO Assistant Manager. Mr. Peters told both Special Agent LaFlair and us that after speaking with Mr. Bassler and Mr. Peters, Mr. Naccache offered to treat the two men to lunch so they could work their problems out. Mr. Peters expressed concern that Mr. Naccache did not take further action.

In June 2007, Mr. Peters sent Acting CMO Manager Bobby Hedlund a memo detailing his continued concern regarding the communications with SWA and Mr. Bassler. Mr. Hedlund told us that the report and discussions had transpired prior to his selection as the Acting CMO Manager; however, he had discussed the events with Mr. Naccache, who retired shortly after Mr. Hedlund's selection. Mr. Hedlund, who had no first-hand knowledge of the conversations between Mr. Naccache, Mr. Bassler and Mr. Peters, related that Mr. Naccache told him what had transpired. According to Mr. Hedlund's understanding, Mr. Comeau expressed concern to multiple SWA CMO employees, including Mr. Bassler, that Mr. Peters might be improperly accessing their maintenance records. Mr. Comeau had a report containing the dates and times that Mr. Peters had logged in, via Imagio, to access SWA CMO records. Mr. Comeau, a former SWA CMO inspector, was aware that Mr. Peters, despite his title of Aviation Safety Inspector, did not perform inspections duties at Southwest Airlines. The principal duties for Mr. Peters as the Data Evaluations Program Manager (DEPM) for the SWA CMO, was to validate data entered into FAA's ATOS system by FAA inspectors.

Mr. Hedlund told us that Mr. Naccache had already informed Mr. Bassler and other SWA CMO personnel who mentioned Mr. Peter's review that Mr. Peters was working at the request of former CMO Manager Mike Mills, and that the work was to continue. Mr. Hedlund stated that Mr. Peters was done with his review of SWA's maintenance records at the time he became the Acting SWA CMO Manager. He said he believed Mr. Naccache, as the Acting CMO Manager at the time the events transpired, had already addressed the situation. Other than a "probabl[e]" follow-up conversation with Mr. Peters, Mr. Hedlund had no subsequent conversations with staff, as it had previously been addressed by Mr. Naccache. Moreover, Mr. Hedlund was aware that Mr. Gawadzinski's relationship with Mr. Comeau and Southwest Airlines was the subject of an

ongoing FAA Security investigation at the time Mr. Peters brought forth his concern.

Mr. Bassler has subsequently transferred to the Dallas-Fort Worth Flight Standards District Office (FSDO), and Mr. Stennis has transferred to the Dallas FSDO. Mr. Stennis was not interviewed due to his extended medical leave throughout our investigation. We also reviewed notes from Mr. Lambert regarding an interview he and FAA Security Special Agent LaFlair conducted with Mr. Bassler; Mr. Bassler's written statements to Special Agent LaFlair, and the House Transportation and Infrastructure Committee during the April 3, 2008 hearing.

Interviews

Five individuals at FAA's SW Region Counsel's office were interviewed regarding a variety of topics, to include the status of the pending enforcement action against Southwest Airlines for the AD overflights, ethics and post employment advice provided to Paul Comeau, and general process questions regarding enforcement actions and the penalty decision process.

Our audit staff spoke to Mr. Comeau, Mr. Gawazinski, and Mr. Ballough without OIG investigative staff present. Southwest Airlines declined to allow Mr. Comeau to be interviewed for investigative purposes; however, they consented to allow him to answer general SWA process questions regarding ADs, with legal counsel present.

No FAA officials outside the Southwest region were formally interviewed as we did not have evidence (to include verbal statements, memos, emails, etc.) suggesting direct involvement of FAA headquarters officials prior to the FAA security investigation which began in early May 2007. Specifically, all individuals interviewed at the SWA CMO and at FAA's Southwest Region headquarters denied elevating, to FAA headquarters, Mr. Boutris's prior concerns of 2005 and 2006, or Mr. Eatmon's report suggesting that Mr. Gawadzinski was overly collaborative with SWA.

Our audit staff met on a couple of occasions with Mr. Ballough and once with Mr. Sabatini prior to the SWA hearing. They did not prepare formal records of their conversations. We have attached excerpts from Mr. Sabatini's testimony during the SWA hearing in which he testified before Congress that he became aware of the Southwest Airlines AD overflight issue in July 2007. In his sworn interview with us, Mr. Stuckey told us he made Mr. Ballough aware of the SWA

issue in late April 2007, shortly prior to the commencement of the FAA Security investigation (early May 2007); however, Mr. Ballough's only comment was that he be kept informed of any findings. We intended to interview Mr. Ballough, primarily to address second-hand anecdotal information regarding his relationship with Mr. Gawadzinski, but were unable to do so as Mr. Ballough was out on extended medical leave and is now retired (with a serious medical condition.) (Exhibit 2 & 3)

REDACTED

WEAT team reviews

The WEAT Team reviews were made at the request of the Regional Manager (Tom Stuckey). Team members consisted of other personnel within the Southwest Region (e.g., managers from other Flight Standards offices). The WEAT team reports were provided to Tom Stuckey and Ron McGarry. In addition, the Jack Jetton and Buford Eatmon reports were provided to Tom Stuckey and Ron McGarry.

Knowledge of the allegation

Mr. Stuckey and Mr. McGarry told us that they did not elevate the AD issue outside the region until late April 2007, and that they had never elevated the 2005 issues with Mr. Gawadzinski outside the Region.

Mr. Stuckey told us he made Mr. Ballough, Director of FAA's Flight Standards Division Office, aware of the potential problem with the SWA AD overflight prior to FAA's security investigation (which commenced in early May 2007). Mr. Stuckey told he advised Mr. Ballough of the AD overflight and potential that Mr. Gawadzinski improperly accepted the event via VDRP via a telephone conversation in late April 2007, after the concerns were brought to his attention by Mr. Mills. He told us he thought he made Mr. Ballough aware of the Region's

transfer of both Mr. Mills and Mr. Gawadzinski, which occurred in May 2007. Mr. Stuckey believed Mr. Ballough notified Mr. Sabatini at some point. Mr. Sabatini, Associate Administrator for Aviation Safety, testified before Congress that he was made aware of the Southwest Airlines AD overflight in July 2007, and that did not have a personal relationship with Mr. Gawadzinski.

As background, Mr. Boutris stated he notified Mr. Mills of the issue in late March, 2007. Mr. Mills, after requesting that Mr. Peters verify the event through some record reviews which took a couple weeks, reported the issue to Mr. Stuckey in early April 2007, along with a request that managers Kermit Teppen and Skip Whitrock from the American Airlines Certificate Management Office (AAL CMO) provide assistance in reviewing the VDRP regarding the AD overflight. On April 19, 2007, the Southwest Region was notified of an FAA Administrator's Hotline complaint, filed April 13, 2007, which alleged collusion between Mr. Gawazinski and Mr. Comeau, a former FAA ASI and the current manager of Southwest Airlines' Regulatory Compliance Program. Mr. Gawazinski and Mr. Mills were moved from the SWA CMO on May 8, 2007.

Document distribution:

We determined that the following documents were distributed as follows:

- a) The July 2005 Mills Memo was emailed to Tom Stuckey and Ron McGarry at the Southwest Region.
- b) The Security Investigation request, dated September 14, 2005, was made from Tom Stuckey to the Manager of the Civil Aviation Security Division (Marty Alford) in the Southwest Region. Mr. McGarry approved the request, and Becky Lindley (now Becky Ramsey) was identified as the point of contact for additional information.
- c) The September 16, 2005, request to withdraw the security investigation was made by Tom Stuckey, provided to Marty Alford, Manager of the Civil Aviation Security Division, and initialed by Ron McGarry.
- d) The Peer Review Team Reports and WEAT reviews were provided to Tom Stuckey and Ron McGarry at the Southwest Region.
- e) The November 2005 Mills Memo titled *Request for Assistance* was provided to Tom Stuckey and Ron McGarry.

All individuals interviewed stated that they did not elevate the 2005 issues to any individual or official at FAA Headquarters.

Ongoing OIG Audit work

The interim audit report released in June 2008 is the last work planned by OIG audit personnel related specifically to SWA. Instead, they began a nationwide audit focused on AD Compliance, which is considered follow-up work to the specific issue of ADs. In additional, OIG audit personnel began a review of FAA's nationwide review of ADs which FAA conducted in spring 2008. However, that audit was suspended in favor of using collected information/data for a possible future House T&I hearing, which is considered a follow-up to the April 2008 hearing. Our audit staff considers their ongoing ATOS audit as follow-up to SWA in that they are trying to determine if the missed key inspections at SWA are an anomaly, or are more widespread amongst the major air carriers. This audit fieldwork has been completed and a draft report is being prepared. We anticipate that this ATOS audit report will be released in mid to late summer 2009.

Follow up to Audit recommendations

On April 13, 2009, FAA provided an additional response regarding recommendations made in a June 30, 2008, OIG audit report which recommended that FAA rotate inspectors, and that they establish an independent organization to investigate inspectors' allegations. FAA had previously non-concurred with the recommendations. In sum, FAA still does not concur with the recommendation to rotate inspectors, and they only partially concur with the recommendation to establish an independent office. FAA's April 13, 2009, response is enclosed as **Exhibit 4.**

Then-Secretary Peters' Independent Review Team (IRT) released its report titled, *Managing Risks in Civil Aviation: A Review of the FAA's Approach to Safety* on September 2, 2008.¹ Among their comments, the panel of aviation and industry experts indicated that the value of detailed knowledge of a specific airline's operation was of value, and "we believe that any enhanced risk of capture can be properly mitigated without mandated rotation..." They proposed an alternate solution, namely that FAA could routinely schedule Internal Assessment Capability (IAC) reviews of any offices where the managerial team has remained

¹ On May 1, 2008, then-Secretary Peters appointed a Blue Ribbon Panel to examine the FAA's safety culture and approach to safety management.

intact for more than a present number of years (e.g., 3-5 years.) A complete copy of this report is enclosed as **Exhibit 5**.

On September 10, 2008, Secretary Peters announced that the FAA would immediately begin implementing the 13 recommendations made by the IRT.

Additional documents requested

- FAA Order 8900.1 is provided at **Exhibit 6**.
- The revised VDRP, effective May 1, 2008, is enclosed as **Exhibit 7**. Permanent guidance has been drafted, but has not been signed by the Associate Administrator for Aviation Safety. FAA has indicated the new, permanent guidance will be issued by May 2, 2009.
- A Notice of Proposed Rulemaking regarding post employment restrictions for inspectors is enclosed as **Exhibit 8**. The projected date for submission to the Office of Management and Budget is May 4, 2009.
- New guidance regarding Air Carrier Evaluation program audits, which would require the audits to be conducted on a regular basis, has not yet been issued, and a draft is not presently available for us to review.
- The ACEP Review of SW Airlines' compliance with Airworthiness Directives is enclosed as **Exhibit 9**. This document is FOUO only.
- DOT Order 8000.1C is enclosed as **Exhibit 10**.

Disciplinary actions

Notices of Proposed Disciplinary Actions and SF-50s were previously provided by OIG to OSC for individuals we identified as having culpability. We have asked FAA's Office of Chief Counsel to update you on the disposition of pending disciplinary actions.

If I can answer any questions or be of further assistance, please feel free to contact me at 202-366-1972, or Erika Vincent, Director of Special Investigations – Transportation Safety at 202-366-1514.

Sincerely,

Rick Beitel

Assistant Inspector General

for Washington Investigative Operations

Index of Attachments

- 1. OIG Audit Report, dated June 30, 2008
- 2. Excerpts from Mr. Sabatini's Congressional testimony, April 3, 2008
- 3. Excerpts from Mr. Stuckey's sworn interview, February 25, 2008
- 4. FAA's April 13, 2009 follow-up response to OIG recommendations
- 5. Independent Review Team report dated September 2, 2008
- 6. FAA Order 8900.1 and interim VDRP
- 7. Revised VDRP, effective May 1, 2008
- 8. Notice of Proposed Rulemaking regarding Post Employment restrictions
- 9. The ACEP Review of SW Airlines' compliance, March 2008
- 10. DOT Order 8000.1C

REVIEW OF FAA'S SAFETY OVERSIGHT OF AIRLINES AND USE OF REGULATORY PARTNERSHIP PROGRAMS

Federal Aviation Administration Report Number: AV-2008-057 Date Issued: June 30, 2008



Memorandum

U.S. Department of Transportation

Office of the Secretary of Transportation
Office of Inspector General

Subject:

ACTION: Review of FAA's Safety Oversight of

Date: June 30, 2008

Airlines and Use of Regulatory Partnership

Programs

Federal Aviation Administration Report Number AV-2008-057

From:

Calvin L. Scovel III C. L. Acovetica Inspector General

Reply to Attn. of: JA-1

To: Acting Federal Aviation Administrator

This report presents the interim results of our review of the Federal Aviation Administration's (FAA) oversight of airlines' regulatory partnership programs and its national program for risk based oversight, the Air Transportation Oversight System (ATOS). We initiated this review in response to a February 6, 2008, request from the Chairman of the House Committee on Transportation and Infrastructure. Specifically, the Chairman requested that we determine whether FAA thoroughly investigated whistleblowers' complaints regarding FAA's oversight of Southwest Airlines (SWA).

The whistleblower allegation focused on SWA's failure to follow a critical FAA airworthiness directive (AD) and an FAA inspector's role in allowing the air carrier to continue flying aircraft in violation of the AD. The FAA directive in this case required SWA to inspect the fuselages of its Boeing 737s for potential cracks that could lead to rapid decompression and fatal accidents. FAA issued this directive after an Aloha Airlines 737 lost a major portion of its hull while in flight at 24,000 feet in 1988, resulting in one fatality and multiple injuries. The Chairman also requested that we determine whether FAA took corrective actions in a timely manner.

The objectives of our initial review were to determine (1) the thoroughness of FAA's investigation of the whistleblower allegations and (2) the type and timeliness of corrective actions taken by FAA in response to any inappropriate

¹ FAA Airworthiness Directive 2004-18-06 requires that Boeing 737s (series 200, 300, 400, and 500) be inspected for fuselage cracks every 4,500 cycles (1 cycle equals 1 take-off and landing) after they reach 35,000 cycles.

inspector actions. At the request of Congress, we continue to review FAA's air carrier oversight processes to determine if there are areas in which FAA could strengthen its oversight. Exhibit A contains our scope and methodology. Exhibit B lists the agencies we contacted or visited.

We testified before the House Committee on Transportation and Infrastructure regarding the SWA matter on April 3, 2008.² We subsequently testified before two Senate subcommittees: the Senate Committee on Commerce, Science, and Transportation, Subcommittee on Aviation Operations, Safety, and Security on April 10, 2008,³ and the Senate Committee on Appropriations, Subcommittee on Transportation, Housing and Urban Development, and Related Agencies on April 17, 2008.⁴

During these testimonies, we made a series of recommendations to improve FAA's air carrier oversight practices. We are continuing our review of these issues and plan to issue a final report later this year. This interim report formally transmits to FAA the recommendations we have identified to date. FAA generally agreed with most of our recommendations for improving controls over its regulatory partnership programs and its national ATOS program. However, FAA did not agree with the two following recommendations, which are fundamental in improving its oversight of air carriers: (1) periodically rotate supervisory inspectors to ensure reliable and objective air carrier oversight and (2) establish an independent organization to investigate safety issues identified by FAA employees. Given the seriousness of the issues these recommendations were intended to address, we believe FAA needs to reconsider its position.

Our complete recommendations, a summary of the Agency's comments, and our response can be found on pages 9 through 12 of this report. FAA's response is included in its entirety in the appendix.

BACKGROUND

According to SWA, it discovered it had violated the AD requiring fuselage inspections on March 14, 2007, and notified an FAA principal maintenance inspector (PMI) the following day. Although FAA requires air carriers to ground non-compliant aircraft and its inspectors to ensure that carriers comply, the inspector did not direct SWA to ground the 46 affected aircraft.

² OIG Testimony Number CC-2008-046, "Actions Needed to Strengthen FAA's Safety Oversight and Use of Partnership Programs," April 3, 2008. OIG reports and testimonies are available on our website: www.oig.dot.gov.

OIG Testimony Number CC-2008-067, "Key Safety Challenges Facing the Federal Aviation Administration," April 10, 2008.

OIG Testimony Number CC-2008-070, "Key Safety and Modernization Challenges Facing the Federal Aviation Administration," April 17, 2008.

Instead, the PMI encouraged SWA to formally self-disclose the AD violation through its Voluntary Disclosure Reporting Program (VDRP), which would allow the carrier to avoid any penalties. FAA accepted the air carrier's self-disclosure on March 19, 2007, even though it had already accepted multiple disclosures on AD violations. SWA continued to operate the non-compliant aircraft on 1,451 flights for 8 days after the carrier first notified FAA, carrying an estimated 145,000 passengers. We estimate that, in total, aircraft flew in violation of the AD for up to 9 months, carrying 6 million passengers during this period.

Once it formally self-disclosed the violation, SWA stated that it was in compliance with the AD, meaning it had inspected or grounded all affected aircraft. However, two FAA inspectors (the whistleblowers in this case) and SWA officials reported that the PMI had knowingly permitted SWA to continue flying the identified aircraft even after SWA's self-disclosure.

During our review, we found that several of these aircraft flew into airports multiple times after SWA self-disclosed the overflight where they could have received the required inspections. When SWA finally inspected the aircraft, it found fuselage cracks in five of them. The AD specifies that these cracks could potentially lead to fuselage separation and rapid aircraft depressurization if left in disrepair.

SUMMARY OF RESULTS

The events at SWA demonstrated serious lapses in FAA's air carrier oversight. We found that FAA's inspection office overseeing SWA (the Certificate Management Office, or CMO) developed an overly collaborative relationship with the air carrier, which allowed repeated self-disclosures of AD violations through its partnership program. We also found significant weaknesses in the Agency's ATOS program, which allowed AD non-compliance issues within SWA's maintenance program to go undetected for years. In addition, we found weaknesses in FAA's (1) processes for conducting internal reviews and ensuring corrective actions and (2) policies for protecting employees who report critical safety issues.

The breakdown in FAA's air carrier oversight occurred because FAA did not implement and enforce effective management controls over its air carrier oversight program. Those controls include the plans, policies, and procedures necessary to meet missions, goals, and objectives and ensure compliance with applicable laws and regulations. Additionally, although FAA implemented an internationally recognized standard for establishing quality management systems, known as ISO-9001, it failed to apply important requirements of the standard. Those

requirements include regularly reviewing and improving Agency processes to ensure they are effective.

Because FAA did not implement and enforce effective management controls over its air carrier oversight programs, including ISO-9001 requirements, the events at SWA were allowed to transpire. Further, because these control deficiencies exist across the ATOS and voluntary disclosure programs, FAA cannot have assurance that these problems are unique to SWA.

FAA has begun actions to address the SWA safety directive violation; these include initiating a review of AD compliance at SWA and other air carriers and proposing to fine SWA more than \$10 million. While FAA's actions are necessary, albeit long overdue, the seriousness of the issues we identified will require immediate and comprehensive changes to FAA's air carrier oversight program.

Overly Collaborative Relationship With the Air Carrier Contributed to Breakdowns in Partnership Program

We found that the CMO overseeing SWA developed an overly collaborative relationship with the air carrier that allowed repeated self-disclosures of AD violations through its partnership program. Partnership programs are intended to encourage data-sharing between FAA and air carriers to identify and address safety issues. Yet, FAA allowed SWA to repeatedly self-disclose AD violations without ensuring that SWA had developed a comprehensive solution for reported safety problems—which is required for FAA to accept the disclosure and absolve the carrier of any penalty.

Clearly, SWA's proposed solutions, which FAA has repeatedly accepted, have failed to solve AD compliance issues as the carrier has violated four different ADs eight times since December 2006, including five in 2008. FAA's oversight in this case appears to allow, rather than mitigate, recurring safety violations.

FAA maintains that disclosure programs are valuable, as they can help to identify and correct safety issues that might not otherwise be obtainable. However, we are concerned that FAA relies too heavily on self-disclosures and promotes a pattern of excessive leniency at the expense of effective oversight and appropriate enforcement. Further, a partnership program that does not ensure carriers correct underlying problems is less likely to achieve safety benefits.

The overly collaborative relationship with the air carrier occurred because FAA did not have the following management controls over its partnership program:

• FAA did not ensure adequate segregation of duties. This entails dividing duties and responsibilities among different individuals to reduce the risk of error or fraud. In the SWA case, the PMI was responsible for both acceptance and closure of the carrier's self-disclosure through the VDRP. The CMO manager was not aware of the significance of the violation, or of the PMI's complicity in allowing the violation to continue, because the program does not require management review of the report at any point in the process.

The events at SWA demonstrated that FAA must implement and enforce a process for second-level supervisory review of self-disclosures before they are accepted and closed—acceptance should not rest solely with one inspector. FAA should also periodically rotate supervisory inspectors to ensure reliable and objective air carrier oversight.

• FAA did not have management controls for avoiding a potential conflict of interest among its employees dealing with the carrier. Specifically, the SWA Regulatory Compliance Manager was a former FAA inspector assigned to SWA who reported directly to the PMI when he worked at FAA. The employee was able to transition from being an FAA inspector to a SWA manager in just 2 weeks. In his new job, he served as the liaison between the carrier and FAA and managed Southwest's AD Compliance Program and its Voluntary Disclosure Reporting Program.

FAA needs to implement post-employment guidance that includes a "cooling-off" period (e.g., 2 years) to prohibit an FAA inspector hired at an air carrier he or she previously inspected from acting in any type of liaison capacity between FAA and the carrier. This type of control is found throughout the Government to ensure that senior Agency officials cannot immediately be employed in a liaison capacity by the organizations they formerly regulated.

• FAA failed to implement management controls to verify the propriety and integrity of corrective actions taken. In the case of SWA, FAA allowed the carrier to repeatedly self-disclose AD violations without ensuring that SWA had developed a comprehensive solution for reported safety problems.

FAA must ensure that its VDRP guidance requires inspectors to (a) verify that air carriers take comprehensive actions to correct the underlying causes of violations identified through self-disclosure programs and (b) evaluate, before accepting a new report of a previously disclosed violation, whether the carrier developed and implemented a comprehensive solution.

Finally, it appears that FAA management fostered a culture whereby air carriers 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. 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 has had a pervasively negative, although unintended, impact on its oversight program. FAA must ensure its air carrier oversight mission clearly identifies the flying public as a primary stakeholder and beneficiary of its inspection efforts. FAA should commit to this in writing and communicate it to all FAA inspection staff.

Missed Inspections at SWA Demonstrate Weaknesses in FAA's National Oversight

Our work at SWA and other carriers found weaknesses in FAA's national program for risk-based oversight, ATOS. At SWA, multiple missed ATOS inspections allowed AD compliance issues in SWA's maintenance program to go undetected for several years. As early as 2003, one of the whistleblowers expressed concerns to FAA about SWA's compliance with ADs. In 2006, he began urging FAA to conduct system-wide reviews, but FAA did not begin these reviews until after the details of the March 2007 disclosure became public.

In fact, FAA inspectors had not reviewed SWA's system for compliance with ADs since 1999. At the time of the SWA disclosure, FAA inspectors had not completed 21 key inspections in at least 5 years. While FAA has subsequently completed some of these inspections, as of April 15, 2008, 4 of these inspections were still incomplete; some had not been completed for nearly 8 years.

We have previously identified system-wide problems with ATOS. For example, in 2002, 5 we found inconsistent inspection methods across FAA field offices for various carriers. As a result, FAA inspectors were confused over how to conduct ATOS inspections and assess risks. We recommended that FAA strengthen national oversight and accountability to ensure consistent field implementation of ATOS. FAA agreed that it needed to strengthen national oversight and stated that the newly appointed director of Flight Standards (at Headquarters) would enhance oversight and hold field offices accountable for implementing ATOS effectively. However, this action still did not improve consistency with ATOS inspections at field offices.

⁵ OIG Report Number AV-2002-088, "Air Transportation Oversight System," April 8, 2002.

In our 2005 report,⁶ we found that inspectors did not complete 26 percent of planned ATOS inspections—more than half of these were in identified risk areas. We recommended, among other things, that FAA strengthen its national oversight and accountability to ensure consistent and timely ATOS inspections. However, FAA still has not fully addressed our recommendations.

Had FAA strengthened its national oversight by implementing effective management controls, it would have been able to monitor the extent to which required inspections were not being performed and it would have been able to intervene earlier to correct the problem. Effective management controls should be designed to ensure ongoing monitoring occurs in the course of normal operations at all levels of an organization.

Ongoing monitoring is also a key ISO 9001 requirement. Those monitoring activities should assess the quality of the program's performance over time and ensure that the findings of audits and other reviews are promptly resolved. Also, because the control deficiencies we found in FAA's oversight of SWA inspections reflect inadequate oversight at the national and regional management levels, FAA executives cannot be assured that the problems that existed at SWA are unique to that location.

FAA must implement a Headquarters-based process to monitor field office inspections. The process should alert local, regional, and Headquarters management of overdue inspections so that immediate corrective actions can be taken. FAA must also develop a national review team that conducts periodic quality assurance reviews of FAA's oversight of air carriers to ensure that (1) appropriate processes and procedures are applied and (2) pertinent policies, laws, and regulations are followed. Ultimately, this quality assurance function should provide FAA executives with reasonable assurance that inspections are completed in a thorough and timely manner.

Events at SWA and NWA Demonstrate Weaknesses in FAA's Internal Reviews of Safety Issues and Protection for Employees Who Report Them

Our work at SWA and Northwest Airlines (NWA) has identified weaknesses in FAA's processes for conducting internal reviews, ensuring corrective actions, and protecting employees who report safety concerns. In the SWA case, FAA's internal reviews found as early as April 2007 that the PMI was complicit in allowing SWA to continue flying aircraft in violation of the AD. Yet, FAA did

⁶ OIG Report Number AV-2005-062, "FAA Safety Oversight of an Air Carrier Industry in Transition," June 3, 2005.

not attempt to determine the root cause of the safety issue nor initiate enforcement action against the carrier until November 2007.

At NWA, FAA's reviews of an inspector's safety concerns were limited and overlooked key findings identified by other inspectors. Although some of the inspector's safety concerns were valid, FAA informed him that all of his concerns lacked merit.

We also have concerns regarding FAA's failure to protect employees who report safety issues from retaliation by FAA managers and other FAA employees. For example, in the SWA case, after one whistleblower voiced his concerns to FAA, an anonymous hotline complaint was lodged against him. According to the CMO manager, the PMI indicated that a SWA representative submitted the complaint.

The complaint was non-specific and never substantiated, but the whistleblower was removed from his oversight duties for 5 months while under investigation. However, unlike the whistleblower, the PMI who admitted he allowed SWA to continue flying in violation of the AD was never completely relieved of his oversight duties; he was merely transferred to another FAA office.

Our work at NWA found the same problem with FAA's handling of the inspector who reported safety concerns. As with the inspector in the SWA case, FAA managers reassigned an experienced inspector to office duties, following a complaint from the airline, and restricted him from performing oversight on the carrier's premises.

The issues exposed at both of these air carriers show that FAA did not establish an appropriate control environment or a reliable internal review process; it also failed to protect employees who identified important safety issues. To prevent recurrence of this situation, FAA should establish an independent organization (that reports directly to the FAA Administrator or Deputy Administrator) to investigate safety issues identified by its employees.

RECOMMENDATIONS

Our recommendations are a result of our work to date on FAA's safety oversight of airlines and use of regulatory partnership programs. At the request of Congress, we are continuing to review FAA's Voluntary Disclosure Reporting and ATOS programs, and we will make further recommendations based on that work. Our interim recommendations focus on basic management controls identified thus far that FAA must implement immediately to ensure it is (1) meeting the missions, goals, and objectives of its air carrier oversight program and (2) fully complying with all applicable laws and regulations.

Accordingly, we recommend that FAA implement the following management controls over the VDRP process:

- 1. Implement and enforce a process for second-level supervisory review of self-disclosures before they are accepted and closed—acceptance and closure should not rest solely with one inspector.
- 2. Ensure that inspectors (a) verify that air carriers take comprehensive actions to correct the underlying causes of violations identified through self-disclosure programs and (b) evaluate—before accepting a new report of a previously disclosed violation—whether the carrier developed and implemented a comprehensive solution.

We also recommend that FAA implement the following management controls over its risk-based ATOS program:

- 3. Develop procedures for periodically rotating supervisory inspectors to ensure reliable and objective air carrier oversight.
- 4. Implement post-employment guidance that includes a "cooling-off" period (e.g., 2 years) that prohibits an FAA inspector hired at an air carrier he or she previously inspected from acting in any type of liaison capacity between FAA and the carrier.
- 5. Ensure its air carrier oversight mission clearly identifies the flying public as a primary stakeholder and beneficiary of its inspection efforts; FAA should commit to this in writing and clearly communicate it to all FAA inspection staff.
- 6. Implement a process to monitor field office inspections and alert local, regional, and Headquarters management to overdue inspections so that immediate corrective actions 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.

Finally, we recommend that FAA implement the following general management control:

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

AGENCY COMMENTS AND OIG RESPONSE

We provided FAA with our draft report on May 28, 2008, and received FAA's comments on June 24, 2008. In its written response, FAA agreed to fully implement all but two of our eight recommendations. FAA did not agree with our recommendation to periodically rotate inspectors (recommendation 3) and partially agreed with our recommendation to establish an independent investigative organization (recommendation 8).

In its response to recommendation 3, FAA stated that it is evaluating the recommendation to periodically rotate supervisory inspectors to ensure reliable and objective air carrier oversight. FAA stated that it is concerned that it would not be practical to require inspectors and their families to relocate on a regular basis. FAA also stated that from a budgetary perspective, the yearly costs of rotating inspectors would be exorbitant.

We recognize the logistical and budgetary constraints this initiative could create; however, we continue to believe that FAA needs a process to ensure objective air carrier oversight by its inspectors. FAA should reconsider its response and develop alternatives that would address the intent of our recommendation to provide greater assurance that FAA inspectors do not develop overly collaborative relationships with the air carriers they oversee.

Possible alternatives could include (a) incorporating assessments to determine if there is an overly collaborative relationship between inspectors and the air carriers they oversee into FAA's Air Carrier Evaluation Program and establishing a process for reassigning those inspectors who have developed such relationships and (b) modifying FAA's aviation safety inspector training program to include additional sensitivity and integrity training for air carrier relations. Accordingly, we are requesting that FAA reconsider its position regarding this recommendation and provide us with alternative planned actions.

In response to recommendation 8, FAA stated partial agreement because it has already deployed the Safety Issues Report System (SIRS) Process to provide an avenue for employees to resolve safety issues without fear of repercussions and to document issues and decisions to promote consistency in the application of safety standards.

FAA's response is unacceptable. Although FAA stated that it partially agreed with our recommendation, the actions taken do not demonstrate a commitment on FAA's part to address the root causes of the issues we identified. Our work at SWA and NWA identified serious weaknesses in FAA's processes for conducting internal reviews, ensuring corrective actions, and protecting employees who report safety concerns.

In our view, SIRS merely adds one more process to an already existing internal reporting process within the Aviation Safety Organization that is unequivocally ineffective and possibly even biased against resolving root causes of serious safety lapses. Implementation of SIRS does not address the intent of our recommendation, which was to establish an *independent* organization (reporting directly to the Administrator or Deputy Administrator) to *investigate* safety issues identified by FAA employees. Accordingly, we are requesting that FAA reconsider its position regarding this recommendation.

FAA concurred with our remaining recommendations (1, 2, 4, 5, 6, and 7). Specifically, FAA agreed to:

- Revise FAA Order 8900.1, Flight Standards Information Management System, to require field office management to sign off on acceptance of a VDRP report and ensure that the operator has completed the comprehensive fix appropriately before closing out the VDRP report. FAA published interim guidance to this effect on May 1 and plans to incorporate this policy change into permanent guidance by September 30, 2008.
- Amend FAA Order 8900.1 and the VDRP Advisory Circular to emphasize reviewing the comprehensive fix proposed by the operator to ensure it addresses the issue being reported. FAA will also update inspector guidance to ensure principal inspectors and management consider the nature of each report, including repeated reports of the same regulation. FAA plans to complete this action by May 1, 2009.
- Initiate a rulemaking to establish a 2-year cooling-off period for FAA inspectors. The Rulemaking Project Record, which starts the rulemaking process, was approved on May 15.
- Reiterate its commitment to the safety of the flying public by having the Associate Administrator for Aviation Safety visit every FAA Region.
- Modify its Aviation Safety Dashboard to show the percentage of the ATOS inspections assigned and completed, those that have not been assigned, and the reasons for the unassigned. FAA agreed to send Alert Notifications to the regional division managers at the end of each calendar quarter.
- Revise its guidance to require Air Carrier Evaluation Program audits to be conducted on a regular basis.

We consider FAA's planned actions to these recommendations to be responsive and therefore consider them resolved pending completion. If properly

implemented, FAA's actions should significantly enhance its oversight of air carriers and its use of regulatory partnership programs.

ACTIONS REQUIRED

We request that FAA reconsider its position regarding recommendations 3 and 8 and provide us with a revised response to those recommendations within 15 calendar days. FAA's planned actions are responsive to the intent of our other recommendations and we consider those recommendations resolved pending completion of the planned actions.

According to Department of Transportation Order 8000.1C, we will follow up with FAA on recommendations 1, 2, 4, 5, 6, and 7 to ensure its corrective actions are consistent with the intent of those recommendations.

We appreciate the courtesies and cooperation of FAA representatives during this audit. If you have any questions concerning this report, please contact Lou Dixon, Assistant Inspector General for Aviation and Special Program Audits, at (202) 366-0500.

#

cc: Anthony Williams, ABU-100 Martin Gertel, M-1

EXHIBIT A. SCOPE AND METHODOLOGY

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted this review between February and March of 2008.

Two FAA inspectors alleged that SWA was permitted to operate aircraft in violation of a mandatory airworthiness directive because of an overly collaborative relationship between the local FAA inspection office and the air carrier. These inspectors requested protection under the Whistleblower Act. In February 2008, the House Committee on Transportation and Infrastructure requested that we review FAA's handling of the SWA matter and examine FAA's oversight from a national perspective. To accomplish this, we performed work at FAA's Southwest Regional Office, two FAA certificate management offices, a Flight Standards District Office, and Southwest Airlines. Throughout our review, we contacted FAA Flight Standards Service officials to apprise them of our review progress.

To obtain details about the allegation, members of the Office of Inspector General audit and investigative staff interviewed the whistleblowers at the local FAA certificate management offices in Irving and Fort Worth, Texas, in February 2008. We also analyzed inspection data from FAA inspection databases to determine the validity of the allegations. We obtained inspection reports from these data sources to identify strengths and weaknesses in FAA's surveillance of SWA as related to the whistleblowers' concerns.

To determine whether FAA's Security and Hazardous Materials Division thoroughly investigated the whistleblowers' complaints regarding FAA's oversight of Southwest Airlines, we reviewed the Division's report of investigation and interviewed the investigator that completed the review. The investigative report contained numerous interviews of FAA personnel and served as a basis for our selection of individuals to interview to obtain further information.

The Committee also requested that we examine FAA's oversight from a national perspective and provide any recommendations to strengthen FAA's oversight of the air carrier industry. Over the next 6 months, we plan to conduct a series of audits to address the Committee's concerns in this area.

EXHIBIT B. AGENCIES VISITED OR CONTACTED

Federal Aviation Administration

Headquarters:

Flight Standards Service

Washington, DC

Regional Offices:

Southwest Regional Office

Fort Worth, TX

FAA Security and Hazardous Materials

Division

Fort Worth, TX

Certificate Management Offices (CMO):

Southwest Airlines CMO

Irving, TX

American Airlines CMO

Fort Worth, TX

Flight Standards District Office (FSDO):

Dallas-Fort Worth FSDO

Fort Worth, TX

Air Carrier

Southwest Airlines

Dallas, TX

APPENDIX. MANAGEMENT COMMENTS



Federal Aviation Administration

Memorandum

Date:

June 24, 2008

To:

Matthew E. Hampton, Deputy Assistant Inspector General for Aviation and

Special Program Audits

From:

Ramesh K. Punwani, Assistant Administrator for Financial Services/CFO

Prepared by:

Anthony Williams, x79000

Subject:

OIG Draft Report: Review of FAA's Safety Oversight of Airlines and Use of

Regulatory Partnership Programs

Thank you for providing us the draft report of your audit of "Review of FAA's Safety Oversight of Airlines and Use of Regulatory Partnership Programs." We agree that there were serious lapses on behalf of some individuals at the Southwest Certificate Management Office and the Southwest regional office. We value the Report's recommendations and will implement each to the extent they are practicable. In general; we believe that introducing additional management controls in programs such as the Voluntary Disclosure Reporting Program (VDRP) and the Air Transportation Oversight System (ATOS) will be beneficial. These are extremely valuable programs in terms of their contributions to FAA's safety mission. We look forward to the OIG's continued review of ATOS. Your evaluations and recommendations are a valued contribution to our continuous improvement process.

OIG Recommendation 1: Implement and enforce a process for second-level supervisory review of self-disclosures before they are accepted and closed--acceptance and closure should not rest solely with one inspector.

FAA Response: Concur: On May 1, the FAA published interim guidance for inspectors in the form of Notice 8900.39, Requiring Appropriate 14 CFR Part 119 Corporate Officer and FAA Office Manager Signatures for the Voluntary Disclosure Reporting Program. In this guidance we require the certificate holding district office management to sign off on acceptance of a VDRP. Management must also assure that the operator has completed the comprehensive fix appropriately before closing out the VDRP. We will have this policy change fully incorporated into our permanent guidance, FAA Order 8900.1, Flight Standards Information Management System, by September 30.

On May 1, the FAA published interim guidance for operators in Information for Operators (InfO) 08021, explaining both the requirement for FAA management sign-off and for a key management official in the airline to sign-off on the VDRP submission. We will include this change in an update of Advisory Circular 00-58, Voluntary Disclosure Reporting Program, also by September 30.

OIG Recommendation 2: Ensure that inspectors (a) verify that air carriers take comprehensive actions to correct the underlying causes of violations identified through self-disclosure programs and (b) evaluate--before accepting a new report of a previously disclosed violation--whether the carrier developed and implemented a comprehensive solution.

<u>FAA Response</u>: Concur: The notice issued on May 1 stressed management involvement by both the operator and the FAA concerning the initial report and its close-out. We will amend the VDRP portion of FAA Order 8900.1, and the VDRP advisory circular to emphasize reviewing the comprehensive fix proposed by the operator to assure it addresses the issue being reported. As well, we will update that guidance to make certain that FAA principal inspectors and management take into consideration the nature of each report, including repeated reports of the same regulation. We will provide specific examples in the guidance when appropriate. Order 8900.1 will be updated before the notice expires on May 1, 2009.

<u>OIG Recommendation 3</u>: Develop procedures for periodically rotating supervisory inspectors to ensure reliable and objective air carrier oversight.

FAA Response: Non-Concur: FAA is evaluating this recommendation, but is concerned that it is not very practical to require inspectors and their families to relocate on a regular basis. Additionally, from a budgetary perspective, the yearly costs related to a rotation of the work force every 3 years (moving 1/3 per year) would break out as follows: Principal Inspectors -- only \$12 million; Principal Inspectors and Managers -- \$27 million, and for all Flight Inspectors --\$129.3 million.

<u>OIG Recommendation 4</u>: Implement post-employment guidance that includes a "cooling-off" period (e.g., 2 years) that prohibits an FAA inspector hired at an air carrier he or she previously inspected from acting in any type of liaison capacity between FAA and the carrier.

<u>FAA Response</u>: Concur: The FAA is implementing this recommendation through a rulemaking that would establish a 2-year cooling-off period. During this period, a former FAA inspector hired by an airline he/she previously inspected could not represent that airline to the FAA. The Rulemaking Project Record, which starts the rulemaking process, was approved May 15.

<u>OIG Recommendation 5</u>: Ensure its air carrier oversight mission clearly identifies the flying public as a primary stakeholder and beneficiary of its inspection efforts; FAA should commit to this in writing and clearly communicate it to all FAA inspection staff.

<u>FAA Response</u>: Concur: The Associate Administrator for Aviation Safety (AVS) has visited or has scheduled visits to every Region and to the Aeronautical Center to reiterate our commitment to the safety of the flying public. We are considering the most effective way to communicate this commitment to all employees.

<u>OIG Recommendation 6</u>: Implement a process to monitor field office inspections and alert local, regional, and Headquarters management to overdue inspections so that immediate corrective actions can be taken.

<u>FAA Response</u>: Concur: The AVS Dashboard has been modified to show the percentage of the ATOS assessments assigned and completed, and those that have not been assigned and why (for example, because of lack of resources). This Dashboard is reviewed by the AVS Management Team

monthly. Alert Notifications are sent by the Flight Standards Certification and Surveillance Division to the regional division managers at the end of each calendar quarter.-

<u>OIG Recommendation 7</u>: 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.

<u>FAA Response</u>: Concur: The Air Carrier Evaluation Program (ACEP) is currently in place as part of the ATOS system. We will change our guidance to require these audits on a regular basis. The Flight Standards Service Director will convene periodically a team of FAA executive level safety professionals to determine ACEP focus areas based on analysis of current conditions, such as trends in surveillance, outsourcing or financial conditions. We will analyze results of focused ACEP campaigns to direct corrective measures. Additionally, the Flight Standards Evaluation Program (FSEP) will be used to assess whether FAA offices operate according to national policy. The Flight Standards field managers and supervisors make up 6 FSEP audit teams. The yearly audit schedule assigns audit teams to 30 offices throughout the Flight Standards organization, and auditors cannot evaluate any office within their region. AFS-I receives quarterly audit reports containing all finding and trends. All FSEP transmittals are entered as corrective action reports into the quality management system.

<u>OIG Recommendation 8</u>: Establish an independent organization (that reports directly to the FAA Administrator or Deputy Administrator) to investigate safety issues identified by FAA employees.

<u>FAA Response</u>: Partially Concur: AVS deployed the Safety Issues Report System (SIRS) Process on April 30 to provide an avenue for employee to gain resolution of safety issues without fear of repercussions, and to document issues and decisions to further promote consistency in the application of safety standards. To date, 24 potential issues have been sent in (since the hearings)--18 of these were sent by electronic mail directly to the Associate Administrator for Aviation Safety, and 6 were entered into the SIRS automated system since it was deployed at the end of April. Of the total, 11 were appropriate to be accepted in SIRS; the remainder included items related to personnel issues and employee messages of support to the Associate Administrator.

CONGRESSIONAL TRANSCRIPTS Congressional Hearings April 3, 2008

House Transportation and Infrastructure Committee Holds Hearing on FAA Airline Safety Regulatory Abuses

LIST OF PANEL MEMBERS AND WITNESSES

OBERSTAR:

The Committee on Transportation and Infrastructure will come to order.

Before we begin the hearing which is the subject of today's session, I have a housekeeping item to attend to, to welcome the newest member of the Committee on Transportation and Infrastructure, the gentleman from New Jersey, Mr. Sires, who replaces our former colleague from Indiana, the late Julia Carson.

Mr. Sires, unfortunately, is still in New Jersey, because they have a filing deadline for the November election and he has to be there in person to do that. But he assured me that he will be an active, vigorous participant in all the work of the committee as we continue our work.

Ms. Carson's untimely death created vacancies on the Subcommittee on Highways and Transit and Subcommittee on Railroads, Pipelines and Hazardous Materials.

The Democratic caucus of the Committee on Transportation and Infrastructure unanimously recommended Mr. Sires fill these positions.

So pursuant to the rules of the committee, I ask unanimous consent that Mr. Sires be appointed to the Subcommittee on Highways and Transit and to the Subcommittee on Railroads, Pipelines and Hazardous Materials.

Is there objection?

The chair hears none. So ordered.

At the outset, I want to observe that we will have, as I've notified members, only

without authority, so to speak?

SCOVEL:

Mr. Petri, it's our understanding that, in fact, he did know officials at FAA headquarters. Now, to the extent he's embellishing his relationship with them so he could puff himself up in the eyes of colleagues down at the Southwest CMO, that appears certainly to have been happening, as well.

PETRI:

Any of you like to respond? Mr. Sabatini? I think both of your names have been mentioned.

Mr. Stuckey?

STUCKEY:

Yes, Mr. Petri, that you very much for the opportunity.

Yes, it is true. I know Doug Gawadzinski just like I know a lot of my workforce. I spend a lot of time on the road to interact with those folks.

Mr. Gawadzinski came to New York when Nick and I were in New York together and spent 90 days on a detail. He went back to the Southwest region and in the period of time since 2001, since I became the director of flight standards service, I have talked to him or seen him a very limited number of times.

Certainly, the portrayal today of daily conversations with Mr. Gawadzinski or the inference by the management in the Southwest CMO that I somehow had some kind of relationship with Mr. Gawadzinski is just not factual, sir.

I'll state for the record that I have been absolutely consistent from the day I joined -- became the director of this organization and went out and talked to the field. I attend every management team meeting at the regions and speak to the supervisory ranks, as well as visit offices.

And I have been absolutely consistent for the last seven years that I expect, number one, standardization. Number two, the issue of following national policy is

paramount for me. It always has been.

So this notion that he somehow had some dispensation for following national policy is a fabrication.

Thank you, sir.

OBERSTAR:

Well, Mr. Sabatini, you knew on July 12, 2007 of the incidents at Southwest. A report was completed, correct?

SABATINI:

I'm not sure of the exact date, sir. But certainly in...

OBERSTAR:

In July.

SABATINI:

Around that timeframe, that would be correct.

OBERSTAR:

That's the date given to the document of completion of the inquiry.

Why did you wait until March of this year to audit other airlines?

SABATINI:

We didn't know the gravity at that time of what was going on at the Southwest CMO.

OBERSTAR:

Shouldn't something have gone off and said, "Well, maybe we ought to take a look at the systems? Since we're operating on a system, ATOS, maybe there's something else amiss?"

What I'm getting at is that there's an over-reliance on ATOS and that if it's so successful, then why is it that old-fashioned inspector feet on the ground, on shop floors and in engine rooms are finding airworthiness directive compliance issues affecting hundreds of aircraft.

In other words, you need more people, you need more inspectors, you need more hands-on work, and I want you to think hard about this. And notwithstanding directives from Office of Management and Budget, we've gone through this with other FAA leadership in years past and other administrations, work with us to develop an inspector workforce need list that we can realistically deliver on.

Will you do that?

SABATINI:

You have my commitment, Mr. Chairman.

OBERSTAR:

Thank you.

Now, the customer service initiative, what do you think about -- what was your reaction, what was your gut reaction when you heard the statement in the earlier testimony from the whistleblower panel that the customer, Southwest, called the FAA and complained about the service they were getting from Boutris, to get him removed?

What was your reaction to that?

SABATINI:

Unacceptable. That's simply an abuse of what the customer service initiative was intended to be. It was to place a mechanism to allow citizens of the United States

who contact the FAA to express whatever concerns they may have, but not to be used as a vehicle to accommodate a like or dislike about a particular inspector.

I will say time and time again, we are responsible for enforcement. Voluntary programs have not abandoned enforcement. We will continue to enforce the regulations.

Our mission is to gain full compliance and to operate at the highest levels of safety. You have my commitment, Mr. Chairman.

OBERSTAR:

Then I hope I have your commitment also to revisit this customer service initiative and rename it and redirect it and thereby redirect back to its original purpose the mission, the safety mission of FAA.

SABATINI:

You have my commitment, Mr. Chairman. I am planning to do that.

OBERSTAR:

Thank you. That may be the most significant thing accomplished today.

Are there others who have -- Mr. Costello?

COSTELLO:

Mr. Chairman, I really do not have any other questions, but I would like to make a comment and express a concern.

And that is Mr. Sabatini has been before our subcommittee many times and we've talked about safety and other issues. Frankly, my concern is this.

It's that you have pointed out, and rightly so, that 99 percent of the planes that have been recently inspected are in full compliance, and, frankly, I think that the agency continues to rely on the fact that we have the safest system, aviation system in the world.

1	UNITED	STATES DEPARTMENT OF TRANSPORTATION
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10		Sworn Interview of Tom Stuckey
11		Case Number 083R0033001
12		On February 25, 2008
13		at 1:50 p.m. CST
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18		Interview conducted by
19		Senior Investigator Erika Vincent
20		Program Manager Tina Nysted
21		Senior Analyst Kevin George
22		Analyst Mark Perrill
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meet with the CEO of an airline, to get an airline to do something that they don't want to do and it's going to cost them millions of dollars, and Bobby has those skills. But my expectations of him is that, you know, we won't have any recurring issues or -- I mean if we do, we'll take the appropriate action.

BY UNIDENTIFIED SPEAKER:

Q Did Doug Gawadzinski have skills? He spent a lot of time over there from what we understand. He had his own standing meeting availability over there.

A I don't think I ever observed at Southwest

Airlines, in that same kind of setting -- I may have been
there when he was there but he probably didn't play a
lead role. I guess Doug probably has pretty good
consensus building skills and, and communication skills.

I never seen him under fire. He did get the airline to
do things that they wouldn't want done in the past.

BY INVESTIGATOR VINCENT:

Q I'm going to change topics here. On the AD issue, did you notify Jim Ballough about when he found out?

A Uh-huh. Pretty early on. I don't know the date but Jim and I normally talk at least once a week. I save up some items because I know his schedule is very, very busy. Yeah, early on in that I'd tell him I think

 \parallel we've got a problem here.

Q So probably April, May timeframe. Well, May is when you sent it to Civil Aviation Security. Maybe May or June.

A No, it would have been before I sent it to Security.

- Q Okay.
- A It probably would have been late April.
- Q Did he make any recommendations to you as to what kind of steps you could take?

A No, but he just expects that we'll follow
Agency policy and Jim and I have a good working
relationship. We see eye to eye on almost everything.
Usually what I do is just keep him updated and if he
thinks I need to change headings a few degrees, he'll
provide that input. That's what so easy about working
for Jim and Nick. There's no hidden agenda.

Q Uh-huh.

A If he thinks I'm heading the wrong direction, he'll say, no, Tom, don't do that. Go over here. And I value that input but on Doug, it was more of keeping him updated and then when we decide to take Doug and Mike out of their positions and do an investigation, I would have coordinated that with him. When I selected Bobby as the permanent manager, I would have coordinated that with

2675	him. I may have told him about selection of the POI.
2676	Normally it's just managers. And I also do that because
2677	Jim's been the principal maintenance inspector on large
2678	air carriers. So he can give me some valuable feedback.
2679	Q Okay. Did he make Nick Sabatini aware of this?
2680	A Yeah, I believe he did.
2681	Q So as far as you know, Nick is aware of this
2682	whole AD, the overflight and the rudder issue.
2683	A The overflight, yes. The rudder PCU, I don't
2684	think that was very egregious. If that was all that
2685	happened, I would not have called Jim.
2686	Q Okay.
2687	A But anytime that inspectors allow airlines to
2688	operate contrary to rules knowingly, that's something
2689	that you always elevate.
2690	Q So how about Bobby Sturgill (ph.). Has he been
2691	briefed on any of this or
2692	A I don't know.
2693	Q or Marian (ph.) would have been back at that
2694	time?
2695	A I don't know. If Nick felt it necessary, he
2696	would have. I don't recall I know some things that we
2697	do, they do brief them and I usually hear about it. I
2698	don't recall any conversation on that.
2699	Q Okay. So essentially your conversations were
	1



Memorandum

Date:

APR 1 3 2009

To:

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Audits

From:

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Subject:

Updated Response to Recommendations 3 and 8 in Final OIG Report "Review

of FAA's Safety Oversight of Airlines and Use of Regulatory Partnership

Programs"

AV-2008-057, June 30, 2008

Below is the Federal Aviation Administration's (FAA) revised response to Recommendations 3 and 8 in the subject report.

OIG Recommendation 3: Develop procedures for periodically rotating supervisory inspectors to ensure reliable and objective air carrier oversight.

FAA Original Response: Nonconcur. FAA is evaluating this recommendation, but is concerned that it is not very practical to require inspectors and their families to relocate on a regular basis. Additionally, from a budgetary perspective, the yearly costs related to a rotation of the work force every three years (moving a third per year) would break out as follows: for Principal Inspectors only -- \$12 million; for Principal Inspectors and Managers -- \$27 million, and for all Flight Inspectors -- \$129.3 million.

FAA Revised Response: Partially Concur. Both the FAA and the recently released Independent Review Team Report believe any inherent risk that may be associated with length of inspector assignment to one particular carrier for oversight is offset by the benefits of the detailed knowledge that inspectors have on specific airline operations. Also, a recent review of 16 air carriers (see attached) showed the average time an inspector is assigned to an air carrier is 3 years.

To address this issue, the Flight Standards Evaluation Program (FSEP) audits will be expanded to evaluate the safety culture in field offices. Special emphasis will be put on those offices where the managerial team has been in place more than 3 years. We tasked our Quality Assurance Staff, AFS-40, to develop assessment criteria in this area and include them in the FSEP. This should be in place by September 30. FAA also has an Internal Assessment Capability (IAC) Review Process which could be used when needed to address concerns of AFS

top management. The IAC typically focuses on matters that are not under the purview of existing AFS management oversight programs or other FAA/AVS oversight programs.

Also, the FAA Acting Administrator has published a safety policy to reinforce management's commitment to safety. This safety policy is a formal reminder to FAA employees that managers and employees all have roles and responsibilities in accomplishing our safety mission. The policy emphasizes that the United States public is the primary stakeholder and beneficiary of the FAA safety mission.

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

FAA Original Response: Partially Concur. AVS deployed the Safety Issues Report System (SIRS) Process on April 30, 2008, to provide an avenue for employee to gain resolution of safety issues without fear of repercussions, and to document issues and decisions to further promote consistency in the application of safety standards. To date, 24 potential issues have been sent in (since the hearings): 18 of these were sent by electronic mail directly to the Associate Administrator for Safety, and six were entered into the SIRS automated system since it was deployed at the end of April. Of the total, 11 were appropriate to be accepted in SIRS; the remainder included items related to personnel issues and employee messages of support to the Associate Administrator.

FAA Revised Response: Partially Concur. The Acting Administrator published Notice 1100.322 on December 8, 2008 which established the Office of Audits and Evaluations. The office is located in the Office of Chief Counsel; the Director reports directly to the Chief Counsel. This new Office will receive information from the four different FAA hotlines, as well as external sources such as the Department of Transportation Office of Inspector General, Government Accountability Office, and Office of Special Counsel. This Office will perform the following functions:

- Provide a centralized focus for safety related complaints and audits and investigations.
- Analyze data from the Safety Hotline, and the AVS Safety Issues Reporting System (SIRS).
 This program continues to provide an additional avenue for employees to gain resolution of safety issues. Total SIRS submissions: to date, 48 potential issues have been submitted (since the Hearings) and 41 were accepted into SIRS.
- Conduct an initial review of disclosure, complaints and investigation received, including an immediate assessment (in consultation with appropriate parties).
- Review responses for consistency and appropriateness of handling. It will assess whether
 investigation and resolutions are fair, impartial, and in conformance with established
 procedures.
- Ensure all FAA employees receive an unbiased review and proper investigation of safety complaints.

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