Mr. President, Members of Congress,

Although this report substantiates, or partially substantiates, four of the seven allegations included, it fails to address many of the significant matters that I have brought forward. It reflects a serious lack of understanding of the issues (asserting that a Proximity Event is not a loss of separation, for example), and is in great part unresponsive to my allegations. At the same time it appears to be biased in that it attempts to minimize the malfeasance and gross mismanagement by facility authorities by lauding the actions **after** my whistle-blowing, while not addressing, at all, why it was that actions to correct the issues were not undertaken over the years that I had been trying to get them corrected. It ignores the fact that these actions were not the result of the facility's own initiative, but were, rather, imposed upon them as a result of outside pressure and direction from the service area; a pressure that they have fought tooth and nail. It ignores the documented years of inaction after I had first identified the issues and prior to my whistle-blowing allegations as well as not addressing, at all, why it was that facility management was not identifying system events when it was so easy for the service area to do so. It concludes that there is no evidence to substantiate the existence of a culture within Detroit TRACON that interferes with the reporting of operational errors and deviations in confliction with the Central Service Area's conclusions to the contrary and does not explain the discrepancy…(the service area's conclusions were in response to my allegations and were communicated to all facility personnel in an early 2009 mandatory briefing. I received the briefing, along with my crew, from then Staff Manager Whitehurst). Further, the agency's own Safety culture training substantiates the problem agency-wide.

The investigative report is schizophrenic in its disorganized thinking: asserting that *"the evidence does not indicate that TRACON officials have…discouraged employees from reporting such events [operational errors]"* while at the same time concluding *"The Operations Manager's reference to the whistle-blower (employed at the Dallas TRACON) as a 'squealer'…could discourage Frontline Managers from disclosing* ***any*** *aviation safety concerns they may have* [emphasis added]." Additionally, the report seems to accept the July 2008 investigation by Flint Air Traffic Manager Schneider (who has a clear conflict of interest, it must be noted, since he is a direct report to District and ATM Manager Figliuolo, who is included in my whistle-blower complaint). Mr. Schneider was also aware of the published "squealer" document, when he concluded Mr. Boland's attempts were not intended to hinder the reporting of operational errors. If the OIG investigation yields the conclusion that this pejorative and the consequently prejudicial characterization of an individual that exposed a culture of not reporting errors and deviations could hinder the reporting of safety events, how does any of this make sense? One is only to conclude that, in the OIG's estimation, operational errors and deviations are not a safety concern; a thought clearly contradictory to our safety culture and safety risk management training. I could site numerous additional examples; however, I include only one additional note:

The report fails to connect the documented dots in a way that any reasonable person would expect: specific losses of separation that I brought to upper management's

attention were not reported by Operations Managers Boland and Auxier (later reported when it was communicated that I would take it outside the facility) – PLUS - errors and deviations that I took to the service area and that the facility failed to report on a constant and ongoing basis **are** reported by oversight organizations, who direct the facility to start reporting them – PLUS - years of facility executed formal audits failing to identify **a single** operational error or deviation, – PLUS - destruction of voice recordings that were required to be maintained and that rendered validation of said audits, in large part, impossible – PLUS – documented performance counseling related to not supporting management decisions when I point out these shortcomings – PLUS - ludicrously far-fetched local interpretations of national requirements aimed at justifying non-reporting of errors/deviations that had the intended result, and the overturning and imposed corrections to same – PLUS - investigations that find that TRACON controllers have "misperceptions" as to what constitutes a reportable event: the *"'seriousness of the event [in other words: how ugly is it]' determines whether to report an operational error or deviation"* and *"reporting a pilot error or deviation 'for a minor infraction isn't good customer service"* (exactly where did they believe these "misperceptions" were generated?) – PLUS – **a service area report**, briefed to all personnel, that **concluded a management culture of condoning the failure to report errors and deviations** (the specifics of which I cannot include because my repeated requests for a written copy were ignored). All this, the report would have you believe, EQUALS - not a culture that fails to report air traffic events, but rather a *"Quality Assurance Review process...[that] failed to adequately detect and investigate operational errors and deviations"* and a finding *"that there was a personality conflict between the whistle-blower and Operations Manager..."*

With regard to the former conclusion: how utterly ridiculous. Having determined that errors and deviations were not being reported as required, the problem, according to this investigation, is not the fact that individuals (a lot of them, and the same ones that insist my allegations are false) did not adequately investigate and detect errors and deviations; it was the **"process"** that failed to do so. The assertion that it was somehow a process that did not report errors, and a process, I should add, deemed "to comply with FAA Order 7210.56 (which provides direction for the reporting, investigation, and recording of air traffic events)," is appalling. Is a reasonable person really expected to buy that? People, the facility's managers that are required to conduct investigations into these errors and deviations with a regard for the public trust, did not do so, and did not report the events. In the sessions of traffic that I forwarded to the service area's Safety Assurance Group in early February, 2009, my observations were validated without err: in those short sessions three errors, and 11 deviations (8 from one session) were reported. Many more observations I forwarded were similarly validated (in one instance the facility was directed by the service area to report 16 operational deviations from one session that it did not want to report; in another, they were directed to report four operational errors where the facility's managers said there were none). These observations were identical to those reported to my superiors, who, for the most part, failed to report them. (I include a performance document designed to discourage me from further attempts to bring attention to the problem after one such attempt). The facility, over and over again, fabricated disingenuous interpretations then applied them so as to justify the lack of

reporting. Over and over again, they were overturned by higher authority and the facility was directed to report the resultant errors and deviations. If my allegation that it was by conscious design that this required reporting did not take place was not to be supported, then a reasonable person would have to conclude that it was, then, the result of ignorance or gross incompetence. With authority comes accountability, or at least, so I thought. It is awfully convenient to hold no one accountable but rather blame the omissions on the "process." But this is nothing new, anyone who truly understands the Air Traffic Safety Action Program, and its genesis, knows that the agency admitted a systemic failure to report required events and, to the best of my knowledge, absolved all of culpability. How DO you get an individual who is accountable for reducing, and at the same time exposing, events to religiously report them? It is simply against his/her self interest to do so. That is what happened here at Detroit TRACON.
With regard to the latter conclusion, that of a personality conflict between myself and Operations Manager Boland: I am utterly amazed that an investigation written on February 22, 2010 that could not validate Allegation 1 and was somehow not capable enough to effect the review of the operational error I provided in support of the allegation **a month earlier** was somehow insightful/capable enough to come to that conclusion. I am insulted and request a formal apology. My conflict with Mr. Boland (as well as with the other members of management at the facility) was based solely on their disregard for written regulations and for their failure to execute their duties with regard for the public trust. It was based on their insistence that they had the authority to ignore national directives. OM Boland's words: "If I say the sky is green, even if the FAA says it's blue, then the sky is green." I religiously maintained my professionalism in the face of repeated, blatant provocation and did not view any action based on a personality conflict. On the contrary, I have consistently said that Mr. Boland is a charismatic and influential leader; one capable of accomplishing what he sets out to do and effective in how he does so. It just so happens that what he set out to do was to circumvent FAA regulations and the rest of the management team allowed and participated in that circumvention.

I don't think I can address all the shortcomings of the DOT investigation in these comments; it's simply too large a task. However, I offer my presence (and fervently hope that you take me up on the offer), at your convenience, to provide more detailed and documented specifics/ explanations, especially as regards allegation 7. I will be glad to testify before congress if deemed appropriate. I encourage the use of polygraph examinations for myself, as a minimum, as well as for my peers and superiors. The truth is that every manager at our facility knew that it was by design that errors and deviations were not reported. It is a dangerous dynamic to put the same people who are responsible and accountable for reducing system events in charge of reporting them. There is a built in conflict of interest in which self-preservation usually wins out.

My comments, although not exhaustive, on each finding follows.

Allegation 1: First of all, as displayed elsewhere in the report, the wording reflects a lack of understanding of my allegations and the issues I presented. One example is the statement that the interviews with the Frontline Managers revealed that none had recalled a missed approach at any satellite airport that resulted in a loss of separation (If I

understand this concept, the investigators were asking the individuals that I allege are purposely not reporting operational errors and deviations if they recall operational errors that they would not have reported in the first place, and then using this as some sort of valid information when trying to substantiate/repudiate my claims). The validity of the above question and answers aside, my allegations speak to the requirements to protect the missed approach airspace under non-radar rules subsequent to the loss of radar contact, regardless of whether or not the aircraft actually executes the missed approach, until such time as we receive an IFR cancellation from the aircraft; that, as well as the facility's failure to address the issue. The specifics of non-radar separation are distinct from an executed missed approach where that aircraft is subsequently radar identified. There is a subtle, but significant distinction either not understood by the investigation's reporter here, or ignored, that should have been understood by AOV as a minimum, but apparently was not. Also, the report notes that:

> *"We interviewed five current and former Frontline Managers who worked with the whistleblower at the Detroit TRACON, and none recalled a missed approach at any of Detroit Metro's satellite airports that resulted in a loss of separation. Although some of the Fronline Managers we interviewed did not demonstrate adequate knowledge of requirements for separating non-radar aircraft from radar identified aircraft..."*

Is the report trying to say that FLMs who don't understand the non-radar separation requirements may have any instructive input in regard to whether they were adhered to or not? Other than identifying the number of FLMs that did not know the rules, why even include them in the five that were polled with regard to the correct application of them? How many of these FLMs did demonstrate adequate knowledge of the rules? How many were left after those "some" are removed? One? Two? How many that understood the rules followed the rules? The investigators were aware that my performance was deemed as unsatisfactory for refusing to certify that non-radar training was accomplished, when, to the best of my knowledge, it was not. This was easily substantiated as I provided the signed memorandum that documented my unsatisfactory performance (see attached). They should have found that these same FLMs that did not know the rules were certified by upper management (probably by the Operations Managers) as having been adequately trained in the rules (they weren't) as well as that these same FLMs certified that individuals under their supervision were trained in the rules that they themselves, apparently, did not understand. Couple this with the general lack of understanding of non-radar requirements that the investigation seems to substantiate, as well as the length of time I have been trying to get this issue addressed, and a reasonable individual should be able to determine negligence, as a minimum. The truth is, however, that the facility did not want to determine the correct standard because they knew it would result in a negative impact to efficiency. Moreover, however, it should have troubled the investigators that an FLM (myself) was told his performance was unsatisfactory for not certifying that non-radar training took place in the face of their identification of inadequate knowledge of the non-radar rules. The knowledge was inadequate because it was never trained. Did they check to find out what training was represented to have been accomplished and when it was accomplished? The fact that unsatisfactory performance

is the determination when I would not falsify training certifications speaks to my allegation that pressure was put to bear to stifle my identification of procedural noncompliance. This is not even mentioned in the report.

With regard to the failure to separate the Oakland/Troy (VLL) instrument arrival aircraft from Oakland County International (PTK) arrivals and departures, only one question needed to be asked by the investigators to substantiate my allegation that separation was not routinely maintained. Apparently the question was not asked. You see, after my allegation, and in agreement with my assertions, the service area, among other things, directed the facility to stop arrivals and departures into PTK once radar contact has been lost on an aircraft cleared for the VLL VOR approach. The only question that needed to be asked in order to substantiate that part of my allegation was: "Did you routinely stop these aircraft after the issue was known and prior to that service area direction?" The answer is no, we did not (why would the service area direction have been required?). The no answer substantiates my allegation. Additionally, and although not exactly this particular example, I forwarded to the OIG and AOV, on January 21, a January 17 event that showed a DTW arrival descending through the missed approach protected airspace of an aircraft cleared into the VLL airport on whom we had lost radar contact and who had not cancelled its flight plan. This spoke directly to the issue, is contrary to the service area direction, and results in an operational error. It should have provided additional substantiation of my allegation that appropriate non-radar separation was not being provided, but apparently was not pursued. This is something that could have been validated easily and immediately. I find this more than just troubling because it demonstrates a lack of thoroughness on the part of the investigators. If there was a bias, and it appears to me there was, it provides evidence of such. I have retained the radar data as proof and can share that proof at your convenience.

The investigative report says:

> *"We reviewed the relevant missed approach procedure for Oakland/Troy airport....and found they were flight-checked, as required under FAA Order 7110.65, to ensure missed approach aircraft safely avoid ground obstacles, such as antennae."*

However, subsequent to the Central Service Area direction to stop PTK arrivals and departures after loss of radar on an aircraft cleared for the VLL VOR approach, the facility misused an interpretation that said alternate instructions could be provided, when radar coverage was sufficient to provide radar vectors, in lieu of the published missed approach procedure to justify not shutting off PTK. It should not have been applied to our situation as our whole problem is generated by the fact that we do not have adequate radar coverage to do so. This resulted in our issuance of missed approach instructions that were not flight checked as required and that were contrary to 7110.65 direction. When I questioned the guidance, the support manager would not produce the interpretation that supposedly supported it. I found the interpretation on-line, and forwarded my objections to facility management as well as the service area's Safety Assurance Group, I was ignored. The investigators were aware of this, were apparently successful at causing the facility to rescind the misapplied guidance, but did not address any of this in the report.

The above notwithstanding, of the greatest concern to me with regard to the veracity of the investigation, however, is the fact that it completely ignores the fact that I brought

this issue to the attention of facility management years ago and revisited it regularly and yet nothing was done about it. This, especially in consideration of the facts regarding the remaining allegations, should have helped to substantiate allegation 7, but was ignored.

Allegation 2: The allegation is substantiated: Detroit TRACON doesn't understand what they are doing in this regard, however, that's kinda not the significant point. The point is I have been trying to get this addressed for numerous years and was ignored/told to shut up. Also, I cannot for the life of me understand how the report can corroborate my allegation that controllers have reduced the 5 mile requirement to 3 miles, yet states it "**may** [emphasis added] have resulted in violations of FAA Order 7110.65." In light of the limitations on radar coverage involved, it does so by definition. Specific electronic data, in light of the admissions, need not be furnished in this instance. Further, referring to these as "violations" instead of operational errors/deviations I find to be biased and misleading. Also, again, the failure to properly identify and train the requirement speaks directly to my allegations; however no such link was mentioned. Under the philosophy: "Don't ask the question, if you don't want to hear the answer," facility management did not want to find out what we should be doing because of the onerous effect on efficiency. Efficiency before safety, that was the rule. Also, electronic data could have, and still can be found on a daily basis to support my allegation contrary to the investigations conclusion; every time the TRACON attempts to utilize this 5 mile separation standard for visual approaches. There is much technical discussion involved with this concept but it boils down to this: without radar coverage to within ½ mile of the runway end, the only options for separation of two inbound aircraft are the timed approach (which does not apply to visual approaches), the tower or pilot providing visual separation, or down time of the preceding aircraft; one of these would need to be applied and we routinely provide none. This is easily identifiable. Lastly, AOV should know what constitutes an operational error or deviation and, consequently, the rules we should be applying. Why is there no such determination here? The report says

> *"It is unclear, however, which portion of FAA Order 7110.65 authorizes the five-mile minimum the Detroit TRACON has chosen." and "If the Detroit TRACON is, in fact, conducting timed approaches by providing the five-mile separation...;"*

a rule exists and is not being applied. This should, and could, have been determined. Well, the report ignores all that and says

> *"**In any event**,*[emphasis added] *in response to ATO-Safety's investigation, the Detroit TRACON Support Manager issued a memorandum...explaining that 'due to inconsistencies in radar coverage' the respective LOA's for Ann Arbor and Detroit City airports require five nautical miles of separation...However, the...memorandum still did not identify a part of FAA Order 7110.65 authorizing five miles of separation."*

Apparently the investigators are happy with this because nothing else is concluded, like: why was PTK not included in the memo; why did not the underlying issue of the identification as to what generates the increased separation requirement get addressed, communicated, trained, especially since the service area specialist, Susan Ruddy, is claiming that she provided guidance to the support manager that the five-mile requirement was indeed the result of the need for a timed approach; why was there no attempt to validate my observations with regard to radar coverage in the first place; why

did Dorothy Davis, Service Area Safety Assurance, direct me, in her 05/20/2009 e-mail correspondence, to *"discontinue the ongoing investigation and data gathering because it is duplicating the effort that is underway"* when no such effort was or is underway besides my own; why do manager's Ancinec and Figliuolo still refuse to entertain my recommendations in this area even after I have provided documented proof of the lack of radar coverage; and most importantly, how many unreported errors and deviations are the result? Further, again, there is no comment/conclusion regarding the inaction of the facility to address the issue before and since my whistle-blowing complaint even though it was/is a known issue. This, especially in consideration of the facts regarding the other allegations, should have helped to substantiate allegation 7, but was ignored.

Allegation 3: O.K., they substantiated my allegation that numerous and persistent unreported operational deviations occurred and continue to occur. Again, it's kinda not the significant point. The point is that I provided documentation that this has been on-going for years, in spite of my efforts to bring attention to it and that it is the result of a management culture of selective enforcement. Why is this not discussed? That discussion would speak to the heart of my allegations, but it is not addressed. What is very troubling in this finding is the implied conclusion that facility management is now doing what it should be doing to correct the issue. A couple of problems here: it is misleading and it ignores allot. It is misleading because it is the Service Area Director, not facility management, who has made the effort to correct the issue. After my allegations, she has imposed on management requirements that they failed to initiate over the many years I have attempted to bring the issue to resolution. The investigation ignores the fact that facility management did nothing but perpetuate the known behavior by condoning the practice. Does it not stretch the bounds of believability to suggest that controllers did not adhere to the boundary separation requirement in spite of a concerted management effort to intervene; that absolutely no deviations were reported even after I provided numerous and specific examples? Additionally, a quick review of the airspace design validates that controllers were not expected to comply with the boundary separation standard. The airspace, in some regards does not reasonably allow for the appropriate boundary separation. Designing the airspace that way to begin with demonstrates intent and a culture of disregard for the rules we should be enforcing. The OIG report ignores the fact that these deviations were not being reported prior to my whistle-blowing actions. As mentioned earlier, it was easily identified in the session that I brought to the service area's attention in early February 2009; specifically that numerous airspace boundary deviations had occurred. The facility identified no such instances in the September data I provided although they were just as obvious. They did so knowingly, utilizing the concept of plausible deniability; a concept that is well honed by these managers. After which, unsatisfactory performance on my part was documented, discipline was administered for not immediately forwarding the errors and upheld even when it became known that I had done so to the Office of Special Counsel, and a disingenuous written Employee Assistance referral was provided based on their claim that something must be wrong with me to make such poorly informed determinations. Again, this, especially in consideration of the facts regarding the other allegations, should have helped to substantiate allegation 7, but was ignored.

Allegation 4: This, as much as any example, shows how deep the cultural failure to apply the agency's own rules extends within the agency. My allegation is partially substantiated because it was identified that the TRACON was not in compliance with the requirement to provide a mile of straight and period of level flight prior to final approach course intercept. However, the report makes further assertions, apparently supported by AOV, that indicate a lack of understanding of the issues as well as failing to respond to my allegations. The report asserts that it could not find evidence that the violations resulted in operational errors or deviations. This should be patently absurd to anyone who understands the English language. The relevant order, JO 7110.65, paragraph 5-9-7, Simultaneous Independent ILS Approaches, states the following (item 4 being the requirement at issue):

> b. The following conditions are required when applying the minimum separation on adjacent dual or triple ILS/MLS courses allowed in subpara a:
>
> 1. Straight-in landings will be made.
> 2. ILS, MLS, radar, and appropriate frequencies are operating normally.
> 3. Inform aircraft that simultaneous ILS/MLS approaches are in use prior to aircraft departing an outer fix. This information may be provided through the ATIS.
> 4. Clear the aircraft to descend to the appropriate glideslope/glidepath intercept altitude soon enough to provide a period of level flight to dissipate excess speed. Provide at least 1 mile of straight flight prior to the final approach course intercept.
>
> *NOTENot applicable to curved and segmented MLS approaches.*
>
> 5. An NTZ at least 2,000 feet wide is established an equal distance between extended runway final approach courses and shall be depicted on the monitor display. The primary responsibility for navigation on the final approach course rests with the pilot. Control instructions and information are issued only to ensure separation between aircraft and to

prevent aircraft from penetrating the NTZ.

6. Monitor all approaches regardless of weather. Monitor local control frequency to receive any aircraft transmission. Issue control instructions as necessary to ensure aircraft do not enter the NTZ.

Please note that in order to be able to utilize the separation minima allowed by simultaneous independent ILS approaches these six conditions are **"required."** Lack of any single one of these requisite conditions would mean that you cannot utilize simultaneous independent separation standards. This would mean that either standard separation or dependent separation standards must be applied. Given the FAA's own definition for operational errors and deviations every one of the intercepts (clearly indicated as documented in the report) where a mile of straight and period of level flight did not exist as required by directive would be an operational deviation as a minimum, and a proximity event or operational error (losses of separation) when less than dependent separation standards resulted. Oddly, there is no dispute that I am aware of that failure to apply subparagraphs 1, 2, 3, 5, or 6 would result in a reportable event. Why the distinction then for subparagraph 4? The answer really lies in the fact that it is/was routinely not complied with nor reported. Reporting this as an operational error/deviation, especially when our safety metrics were based on same, would have resulted in an astronomical increase in losses of separation. So we did not follow the rule, because of an institutional safety culture that said "yeah, were not following the rule, but it's safe," and because of that, and the failure to report, we perpetuated the problem.

Contrary to what the agency and the OIG report would lead you to believe, these are operational errors and deviations by definition. If you substantiate that the requirement was not met, you have substantiated the system event. The only argument that can be made to the contrary is that the 7110.65 did not intend to make them such; that it did not mean what it said. I feel very confident, however, in stating that the agency does not have the institutional memory to make such a claim. There are many other problems with the finding, not the least of which is that the whole discussion of the "Dual Bar" is not germane because, contrary to the report's assertion, it did nothing to address my concerns regarding the period of level and mile of straight flight issue. What it did was try to **compensate for not applying the requirement** by adding-in more altitude separation. The investigators knew this because I explained it to them. I would be happy to explain the details, as I said earlier, at your convenience.

Mr. Boland's absurdly outrageous written interpretation, supported by all other facility management, was not just an innocent document written by some poor, misguided and inept manager. As I said he was an extremely well informed and capable manager (likewise, he was well versed in the claims of the D10/DFW "squealer" although it serves him well to claim he was not). I was already instructed that failure to provide the requirement was not viewed as an operational error or deviation by the facility, this by ATM Figuliuolo, who asserted it was, rather, a performance issue. Consequently, I was counseling controllers on their performance. When Mr. Boland found out I was discussing controller performance in this regard he ordered me to stop and to revisit the

issue with those with whom I had the discussion; to tell them to disregard my input; that it was only my belief and not facility interpretation; and that the facility interpretation would be forthcoming. His ludicrous interpretation was designed to follow-up/cement his verbal direction and prevent even the performance discussions I was pursuing. Previously, the facility, in a disingenuous effort to reclassify an error that I had brought to the attention of Mr. Boland, but was not reported until I threatened to take it out of the facility, were told that they were incorrect in their belief that an aircraft could still be in a turn to join the final approach course, yet somehow be established and out of the "turn-on" for the purpose of discontinuing 7110.65 requirements during dependent ILS approaches. However, notwithstanding that, they tried to get an interpretation that the same was true for independent approaches; that the aircraft did not have to be out of the turn-on phase before the termination of the 1,000 feet/3 nm separation minima. You see they were not reporting these errors based upon OM Boland and Auxier's obviously flawed and purposefully based interpretations designed to result in unreported errors until after I pointed this out to the service area and the service area subsequently forced them to report these errors. In putting the word out to the controllers that these events would now be reported, the Support Manager for Quality Assurance, Mr. Grand, minimized the issue by saying that "technically" these were operational errors. Of importance to the present discussion, however, is the fact that in their request for the interpretation that would justify not having to apply standard separation during the turn-on phase (I attach the request and the interpretation) they supported their position by including the following:

> *"The intercept angles and the **requirement*** [emphasis added] *for one mile of straight flight prior to final approach course intercept serve to minimize the risk that the aircraft will fail to intercept the appropriate localizer."*

What was attempted here is the disingenuous utilization of a requirement, which is not enforced as such, to manipulate the removal of another requirement that was not being enforced until they were made to do so. I provided e-mail documentation to the investigators that demonstrates this failure to report as well as the service area intervention. I am able to provide this, along with explanation, to your offices also. All of this, especially in consideration of the facts regarding the other allegations, should have helped to substantiate allegation 7, but was ignored.

Allegation 5: I will simply say this: Mr. Boland is lying. I was told by Mr. Boland that he expected the certification in question within two weeks of the individual commencing OJT on the position. When I refused to agree, stating that it would be driven by the trainee's performance, not an imposed timetable, the trainee was removed from my supervision. Additionally, the report cites the appropriate order with regards to allocation of training time but indicates that the amount of activity could not be verified (again I assume this is because of the loss of electronic data). However, there are other reasonable ways to provide anecdotal proof of my assertion that hours were credited to accelerate the certification (this because a certain minimum number of hours is required). First, standard traffic flows mean that quite often, a significant amount of traffic is

exchanged between the two sectors (meaning a comparable volume of traffic). Second, the busiest airports in the two sectors are Windsor and Detroit City; both lie in "D" not "K" airspace. Third, the busiest satellite airport in D21 airspace would require transit from "K" to "D" airspace under normal conditions. Fourth, I believe it is true that there was almost always a significantly lopsided allocation to "K" and never the other way around; historical data would provide context as to the probability of this eventuality. The report refers to *"none of the other individuals we interviewed"* corroborated my assertion. Who were these individuals and what was their ability to posses that knowledge? Lastly, the Frontline Manager who executed the improper certification did indeed retire…as soon as he found out about my whistle-blower allegations. He has visited the facility on more than one accession since that time, however, and, as far as I am aware, has not moved from his previous known addresses. As a retiree, I assume the agency knows his whereabouts. This generates questions in my mind as to why he could not be located. Having said this, however, I would expect from him the same self-serving answers that were received from Mr. Boland. Did anyone ask the trainee in question what he knew? This is not simply a "he said/she said" issue. Again, however, I am available for a polygraph examination on the subject.

Allegation 6: As I read the finding, it seems to say that my allegations could not be substantiated because the specific observations that OM Boland made in 2008 could not be reviewed. It is correct to say that they could not be reviewed; however, it is incorrect to say that this means that my allegations could not be substantiated, at least in part. My suggestion to the investigators was for them to execute the survey with an impartial observer (one not from the facility). There is no reason I can think of why AOV could not have gone up to the tower and made at least a few preliminary observations to determine if my allegations as to a lack of the appropriate runway occupancy time may have some validity. Was this done? How about ASDE-X (ground radar) recordings adjusted for the length of the aircraft? Any reasonable person would have to acknowledge that the facility, under duress for its failure to follow its own rules, has a self-serving stake in a survey that supports Mr. Boland's observations as well as a result that reduces required separation. Why would anyone be surprised that a subsequent survey, executed by a facility that the service area agreed had a culture of not following rules when otherwise viewed as safe, does so? Again, efficiency can be put ahead of safety where a culture of selective enforcement exists. But there is an added benefit to the manipulation of this result: if aircraft get closer than 3nm apart, even when snow or ice mean ROTs will be greatly increased, we do not report an operational error. This is how that works at D21: once a ROT that allows for reduced separation is documented and the reduced separation standard is put into effect it is not considered an operational error when aircraft get closer than 3nm. The OMs have made it very clear, the tower is not to tell us that 2.5nm is not available, they are to tell the TRACON that they need additional spacing. This has even been done in situations contrary to the 7110.65 requirement that the tower must be able to see turnoff points.
As for the review by the service area, this is one of form (did the right boxes get checked) not one of veracity (are the observations correct).
I am disturbed by the reports dismissal of OM Boland's omission that he did say he was going to advise the airlines of the survey, as well as the apparent acceptance that he did

not. Did they ask him what the intent of that advisory was? Whether or not one could prove he actually did get with the airlines to solicit the help in achieving the benefit for them, does not the mere train of thought provide insight into his motivations? This, as well as his direction that pilot deviations were not to be reported unless they resulted in a loss of separation (contrary to written regulations) indicate an inappropriately chummy relationship between regulator and those regulated (remember the controller "misperception" that reporting pilot deviations was poor customer service!)
Given my informal observations on ROT, I am convinced that an impartial review (and by this I mean executing a new survey) is more likely to indicate an ROT of greater than 50 seconds rather than less. I am surprised the investigators were not interested in that outcome. Again, it should create questions in the mind of a reasonable individual that should require an answer. Mr. Boland's declared intention to prepare the customer in order to obtain an advantageous result, and the results of an impartial survey yet to be completed, especially in consideration of the facts regarding the other allegations, should have helped to substantiate allegation 7, but was ignored.

Allegation 7: I have tried, in commenting on each of the previous allegations, to show you how and why there was a design at play to limit the reporting of system events. However, since this finding goes to the heart of my allegations, let me briefly touch on the specifics of it. The investigators substantiated that in Quality Assurance Reviews and in facility executed investigations into operational errors and deviations numerous reportable events were not reported. The reporter uses what I believe to be the more benign, and biased, phrase *"Quality Assurance Review **procedures** and investigations into operational errors and deviations...have been **inadequate**."* [Emphasis added]. The reporter then goes on to say, however, that the evidence does not support that this was purposeful. As I attempt to address further findings related to this allegation, please remember that there is no dispute that numerous errors and deviations were not reported by this facility.

The report's author, Mr. Uryga, then goes on to say there is no evidence of the existence *"of a culture within Detroit TRACON that does not allow or support the reporting of air traffic events such as operational errors or deviations or discourages air traffic control staff from reporting such events."* I know I can not provide here the hundreds of pages of documentation that I provided Mr. Uryga, but I will attach and discuss a few in a moment. It should be enough to cause you to doubt this finding. First and foremost, however, is the fact that the early 2009 investigation that is referred to in the report as executed by the Central Service Area, at least as far as I and every person in the facility was briefed, resulted in the opposite conclusion: that there was a culture of management officials condoning (and, therefore, not reporting) system events. The fact that the OIG report finds that no one they talked to agreed with my assertion is understandable as regards facility personnel: it supports my allegation of a pervasive culture; but is alarming if it included discussions with David Auscherman and Nancy Kort as these are individuals who should obviously be aware of the Service Area investigative conclusions. You should be interested in this discrepancy.

The report includes two e-mails written by Mr. Figliuolo, facility manager, that it purports, I believe, offers proof of the facility's stance on reporting errors and deviations (again, I provided many, many more that would controvert this). A few comments: It is an easy and self-serving thing to put into writing a statement that supports the reporting culture. However, one must weight this against what was actually going on at the time. The fact that at the same time Mr. Figliuolo was still not taking any action in attempting to investigate my assertions that operational errors and deviations were not being reported (later substantiated), is to me more significant…actions speak louder than words. Secondly, did the investigators even attempt to find out what motivated Mr. Figliuolo to write this e-mail? The reality of its genesis is that OM Auxier and OM Boland, in a Frontline Managers meeting, had introduced their initiative that would have formalized **knowingly** allowing losses of separation when it was felt they would result in proximity events only, not the more serious operational error. This can be easily inferred by the text: *"…briefing controllers that [proximity events] are okay."* I went to Mr. Figliuolo, who was now aware that I might take such matters outside of the facility, to express my extreme disagreement with the initiative. It was after that discussion that the e-mail was generated. With regard to the second e-mail: I ask you to look at the juxtaposition of the two thoughts contained in it. It starts with the message that very senior management wants *"all operational errors to decrease"* then follows this up with the *"need"* to report errors. As I have stated before, if the same individuals that must show a reduction of errors are entrusted with reporting same, you have created a conflict of interest in which self-preservation wins out. A reasonable person could conclude that if Mr. Figliuolo was sincere in his guidance that all errors be reported, he would not have linked it to a required reduction in reported errors.

The OIG report's author states that there was no corroborating documentation or testimony for my contention that OM Boland told me not to report losses of separation unless they were 'ugly.' It is self serving for ATM Figliuolo to say that he did not recall, in our 12/14/2007 meeting, that OM Boland asserted the following: he did provide me the guidance to not report events unless they were ugly; he did provide the guidance to show controllers to be training when, in fact, it was known that they were on break; he was "rescinding my informal guidance" with regard to not reporting system events and with regard to Cru-Art position assignments; that he did bring up my career when I told him I was going to push his failure to report the 08/06/07 operational error that I brought to his attention, and that he did so in order to "find another way to reach you." Instead Mr. Figliuolo acknowledged *"there was 'some confusion' regarding what the Operations Manage told the whistleblower."* Did anyone ever explain what was told to me and how it created the confusion? Why not? Was this not of interest to the investigators? Did they simply accept this at face value as it is obvious they do with many other self serving claims? Later the OIG report references a March 26,2009 QCR Report (a report that I made numerous requests to see but which were ignored) which documents that Detroit TRACON controllers did not feel they needed to report (and by extension, it is reasonable to deduce therefore, did not report) operational errors or deviations unless they were more serious. Is this not simply a more refined way of saying they felt they did not need to report them unless they were ugly? Where did the OIG investigators think the controllers got this perception? I mentioned one system event that I brought to OM

Boland's attention and that he did not report, there were others. Additionally, on or about 08/07/2007 OM Auxier caused the decertification of controller Ken Moore due to his performance in a session on 08/07/2007. His performance was reviewed, and deemed to be so lacking as to require decertification. What Mr. Auxier did not do, was to report the events (operational error and Proximity Event) that FLM Shoup said were brought to his attention during the review. They were not reported until it was relayed to them by FLM Murphy that I would elevate the issue outside of the facility. These, and similar documented events are not mentioned in the report. Were they not considered by the OIG investigator?

I discussed the "squealer" comment earlier in my comments and simply restate here that it is a flawed report that would claim that at the same time such a characterization would reasonably result in discouraging FLMs from disclosing aviation safety concerns, that the evidence does not suggest that OM Boland did so discourage the reporting of safety concerns, specifically operational errors and deviations. Further, were the investigators not concerned that OM Boland admitted his view that the revelations brought to light by the DFW-D10 whistleblower were having a negative impact on the facility? Did they not want to know why Mr. Boland thought it was the whistleblower's actions in reporting management's malfeasance, and not the malfeasance itself, that had created the negative impact?

Next, the OIG report says it did not find sufficient evidence demonstrating a passive approach to the reporting of errors and deviations. With regard to my claim that it is disingenuous and misleading to publish a call to action that seems to support agency Crew Resource Management initiatives, those of the FLM who is actively engaged in assisting controllers, while, at the same time, directing the single FLM who is doing so not to do so: I am astonished that the investigators ignore the documented confliction in favor of the self serving claim on the part of OM Boland that his direction to me was *"not intended to contradict the Call to Action Plan."* If I understand the investigative methodology here, they utilize Mr. Figliuolo's written, documented, e-mails to verify intention but not Mr. Boland's written direction. It has since been verified that errors and deviations were not reported and that numerous events were occurring (again, 16 operational deviations in one session). In attempting to help controllers avoid/prevent such events in the face of a management team that was doing nothing to do so, I had to intervene and interact with them on the floor. This is expected of the FLM by the agency. To somehow suggest that I could do so without being in their vicinity is laughable. As far as OM Boland's claim about note-taking, I never did so in an overt way. I did do so in the operating quarters, however I always did so at the FLM or TMU desk area. Further, my notes were documenting good as well as wanting performance and were freely shared with the facility and controllers to whom they applied. To say that I was *"focusing too much on the negative aspects of each controller's performance"* also flies in the face performance documents penned before my whistle-blowing allegations that lauded my performance management, stating: *"Tim does an outstanding job of sharing information with the management team...Tim consistently documented controller and TMU performance,* ***more good than bad,*** *and shared them with their supervisors [emphasis added]."* The investigation was aware of this, why was Mr.

Boland's claim not challenged? Lastly, the facility had provided all FLMs with a small note pad, as well as the apparently insincere direction to use it to document performance while in the operating quarters during the shift. What exactly are they trying to pull by criticizing the FLM who is using it? My efforts to comply with that direction should be lauded, not criticized.

While apparently ignoring the documentation I provided the investigators in proving attempts to interfere with the investigation or reporting of system events, only a few of which I provide below, the report does however find a personality conflict. As I mentioned earlier, I am offended and request a formal apology. That said, I include now a few of the additional reasons why, the documentation of which was provided the investigators, I dispute the finding:

- In reaction to my longstanding attempts to bring to the attention of facility management that we were condoning the use of unauthorized, improvised, prearranged coordination without the requisite facility directive my reasoned justification was not pursued and it was my performance that was determined to be the problem. Excerpts from a late 2007 documented performance discussion follows:
    - **Tim needs to be flexible** and Tim needs to understand that **not every single facet of ATC has to have a procedure attached to it!** A perfect example of inflexibility would be when (during convective weather activity) **Tim philosophically struggles** with the "on the fly" coordination that is done in order to keep the customer moving at all times. (Emphasis in the original.)
    - **...due** to Tim's own personal philosophical differences (everything is black and white, there is no gray!) his very strong leadership qualities are **almost completely neutralized by being inflexible and unreasonable.)** Tim expects 100% compliance with his own personal direction and interpretation issued to his subordinates. The flip side of this is that **if Tim does not philosophically agree** with the direction or interpretation issued from his peers or bosses then Tim has a tendency not to support his peers and bosses. In other words Tim wants his cake and eat it to, and this leads to an overall perception that **Tim is always right and everyone else is wrong!** Tim's lack of being flexible and reasonable is disturbing and **creates a less than amicable relationship with his subordinates, peers, and bosses alike.** My expectation is that Tim makes the **choice** to provide an **immediate behavior change** toward being both flexible and reasonable. (Emphasis in the original.)

  It is import to note that the facility never did pursue my claim that we were not following national directives. They allowed the hundreds of operational deviations that were the result to continue. However, although themselves failing to documenting the hundreds of operational deviations that were the result of the practice (why did they not?), the

service area confirmed the correctness of my position and directed the facility to stop the practice (see attached April 9, 2009 memo from Mr. Ancinec).

- After a September 2008 management meeting in which ATM Figliuolo, after acknowledging the years in which I have told him we are not following our own rules, simply polled the FLMs to test the truth of my claims, I reviewed two arrival sessions, identified numerous operational errors and deviations, and submitted them to the OSC as part of the disclosure. A bit naieve as to the timetable for disclosure processing at the time, when it became evident that the data would be lost prior to the disclosure being addressed, I provided the information to facility management in the 10/15/2008 e-mail I attach. The facility did not support my observations and asked for further specifics (while, it should be noted, prohibiting me from utilizing any playbacks in order to accurately and thoroughly provide them...a clear attempt to limit them). Having taken reasonably good notes, however, I responded with the 10/16/08 e-mail that includes the request for information as well as my response. All of this was presented to the OIG investigators.
    - Of the numerous events that I documented, the facility reported only one operational error, one operational deviation, and, I was told one pilot deviation (although I did not see that documented). These observations were similar to later observations that were substantiated, without err, by the service area. One has to ask themselves how could the same person, making the same observations, be so wrong when investigated by facility management, and so right when investigated by others?
    - After the 10/22/08 meeting to which I was summoned with ATM Figliuolo, and OMs Auxier and Boland to review the results of their investigation of my observations, I was provided documented performance feedback that I was performing unsatisfactorily (see attached 11/09/2008 memo). That memo makes it clear that they wanted me to stop my efforts to ensure the reporting of errors and deviations. While I cannot prove that in that 10/22 meeting I was directed not to do any more audits to support my claims, it is clear that that they were not appreciated. Contrary to what is suggested, however, I did not require authorization to do the audit. As an FLM I was authorized to access radar and voice data without restriction and no authorization was required. It is also important to note that, other than my disclosure, at no time did I voice my differences with management to non-management personnel. In other words, I did not communicate to the controller workforce any of this. My differences were kept within management and the service area. The memo also tries to say that my observations

were not accurate, sound, collaborative, respectful or positive, simply because I disagreed with the failure to report errors/deviations. I have been proven accurate and my observations sound by subsequent service area investigations, while theses managers were proven wrong time and time again. I will let you judge the respectfulness of my e-mailed comments. Finally the memo documents unsatisfactory performance for failing to sign non-radar certifications. I did refuse to do so because doing so would have been falsifying government documents. Non-radar training was not taking place. The OIG report has since substantiated non-radar rules were/are not understood, this is not because the training was insufficient, no, it was because it was not accomplished. Lastly, during the 10/22/2008 meeting I broke down briefly. I was being angrily threatened with disciplinary action and I feared the punitive results of which I had been cautioned against by the Merit Systems Protection Board and the resultant impact to my family's well being. I was told in the meeting that there must be something wrong with me for my observations to be so inaccurate (this even though three events were eventually reported when the facility Manager for Quality Assurance said none existed). Because of this I was presented the 10/23/2008 EAP referral. This was disingenuous and an attempt to support impaired judgment rather than to help me with the stress resulting from their actions to suppress my activities to expose malfeasance.

- As I mentioned previously, time and time again, the positions of facility management with regard to what is/is not an error or deviation were overturned. There was no *"reasonable difference of opinion as to what the data showed"* as the managers who were failing to report the events suggest and the report appears to accept. The managers and I agreed on what the data showed; it was their interpretation of the rules that should have applied to that data that was the issue. In every one of the positions I have taken with regard to interpretations in this regard, outside entities have found me to be correct and the managers that criticized my performance to be incorrect:
    - The requirement to be out of turn-on phase prior to loss of standard separation for dependent ILS approaches.
    - The requirement to be out of turn-on phase prior to loss of standard separation for independent ILS approaches.
    - The requirement to have a facility directive in place when applying pre-arranged coordination.
    - The requirements with regard to coordination before taking control actions in someone else's area of jurisdiction.

- The requirement preventing monitor from executing what amounts to a vector to intercept the final approach course without standard separation.
- The requirement to protect the non-radar airspace of the published missed approach when radar contact is lost for aircraft inbound to an uncontrolled satellite airport.
- The then requirement for tower approval to have taken place when an inbound was not established on the extended runway centerline prior to a 4nm final.
- The failure to identify lack of airspace boundary separation.

I believe that a reasonable person, in possession of the documentation that I provided the OIG should have been able to substantiate that the outrageous interpretations there were offered by facility management were a design to limit the reporting of system events. If not however, one has to ask themselves: How can the people that we put in charge of enforcing our rules at Detroit TRACON be so wrong, so often in knowing the intent of the rules? In the absence of a determination with regard to design, it should bring into question a determination as to competence. Specifically, weren't these managers, then, incompetent, negligent, or both? If thousands of unreported errors and deviations, over a six year period, was not enough to inspire the questions, exactly how many unreported errors and deviations would have had to occur before this was considered?

As the OIG report discusses these and other matters, it continuously misrepresents my allegations. In addition to those mentioned previously: I did not say that OM Boland directed me not to use data replay equipment while in the TRACON; I said he directed me not to use the *T function of the STARS radar display while in the TRACON. I did not say that OM Boland told other FLMs that the 2008 Call to Action Plan was meant to mislead others; I said that he told that to me, that I did not know what he told other FLMs but that other FLMs said that he told them that nothing was changing from what we were doing before the call to action. I did not say I was "satisfied" with the current personnel assignments.

I discussed earlier in my comments the strong critical feelings I have for the reports outrageous conclusion that it was the process that failed to report operational errors and deviations, not the individuals that were responsible to do so. This was a conclusion apparently fed to, and accepted by, the investigators without critical examination. It is instructive to note that following several media reported events that revealed that FAA management personnel did not comply with reporting requirements, our Support Manager for Quality Assurance, Earl Grand, used these words to describe the omission: *"In the past few weeks, the FAA has experienced safety events that have revealed some problems with our reporting* ***process*** [emphasis added]."

As far as my objection to not being included in the process, they were these: why would you not include the individual who is alleging the noncompliance in the review of the data? Would you not be interested in his point of view? Moreover, why would you direct him to provide specifics of his observations while, at the same time, preventing his use of investigative tools? If you have an individual who alleges that the facility is routinely not following the rules, why would you not want that person intimately involved in validating that?

I am a second level manager, intimately aware of the management decisions at this facility. In these eighteen pages of comments I have only scratched the surface of the issues involved in my allegations. It is clear to me that the sheer depth and breath of the issues overwhelmed the investigators ability to adequately understand/address them. I hope you will not let these issues die with this shoddy investigative report and sincerely hope that you take me up on my offer to testify about these and other ongoing safety issues.

Thank-You for your time,

Timothy M. Funari,

Federal Aviation Administration

Memorandum

Date: 11/09/2008

From: Tom Boland III, Operations Manager, D21 TRACON

To: Tim Funari, Front Line Manager, D21 TRACON

Subject: Unsatisfactory Managerial Performance – Record of Coaching

This memo serves to inform you of your unsatisfactory managerial performance over the course of the last 90 days based on our FAA-wide managerial (PMS) performance standards.

Achieving Results:

1. **Managing Organizational Performance:**
   - **Supports managerial decisions**

3. **Problem Solving:**
   - **Considers the impacts and consequences of decisions.**

You are not accomplishing these performance objectives.

As a FLM, you are required to support the decisions of the management team and to make good decisions! However, you took it upon yourself to initiate a random operational audit in early to mid September 2008. You failed to keep me informed or to receive my authorization for this unauthorized random audit.

You will meet the Achieving Results expectations by: Fully support all managerial decisions.

Building Relationships:

1. Communication

- **Both oral and written communications contain appropriate accurate information in most instances.**

2. Building Alliances

- **With few exceptions, efforts show adequate collaboration and coordination and result in a positive contribution.**

3. Interpersonal Relations and Influence:

- **Consistently treats others with respect**
- **Develops rapport with other managers.**
- **Efforts typically show sound judgment.**
- **With rare exceptions, issues/problems are identified and resolved in a manner that facilitates a productive work environment.**

You are not accomplishing these performance objectives.

As a FLM, you are required to be accurate and respectful in your communications with the management team and to engage in providing for productive managerial work environment! However, you have taken it upon yourself to inaccurately question our management teams actions. Recent examples are: On 10/16/2008 you stated; *"I must note that if Mr. Grand's review, as mentioned below, was consistent with other facility audits, even a partial validation of the observations I noted above would reveal significant problems/limitations of the audit mechanism employed here, rendering them, in my opinion, as to be practically useless"* and *" I have had to make stands against superiors who have, in the most blatant of ways, tried to intimidate and interfere with my efforts to bring light to these issues"* and finally *"then listening to him (Figliuolo) put it out as a referendum, and noting what ranged from complacency to disdain, with only one FLM (KN) to support me"*.

You will meet Building Relationships expectations by: Demonstrating skills that provide contributions toward a positive and productive management team.

Delivering Products and Services:

- **Utilizes support functions effectively.**

You are not accomplishing these performance objectives.

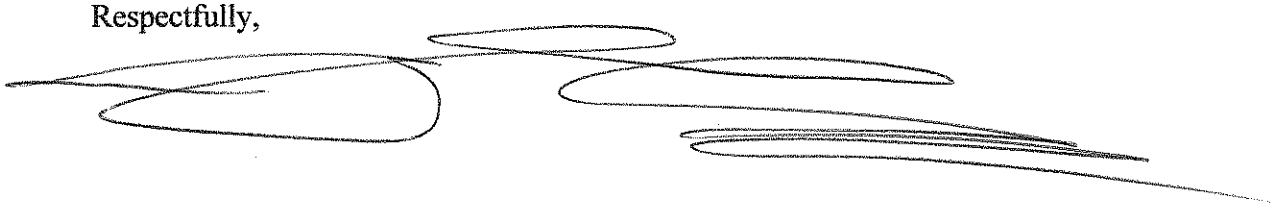
As a FLM, you are required to deliver the products and services directed by senior managers within the ATO. However, on or around 09/19/2008 you personally failed to perform the signatory functions required of ATO Mission Support regarding "non-radar" certifications.

You will meet Delivering Products and Services by: Demonstrating effective skills in delivering products and services by following direction from senior managers.

Tim, you have failed to provide appropriate managerial responses in both your actions and words. Please correct these performance deficiencies immediately.

You are a valued ATO employee, but your current performance is unsatisfactory.

Respectfully,



Tom Boland III

Federal Aviation Administration

Memorandum

Date: APR 1 9 2010

To: Nancy B. Kort
Director, Central Terminal Operations

From: Tony Mello
Acting Director, Terminal Safety and Operations Support

Subject: Request for Interpretation of FAA Order JO 7110.65T, Paragraph 5-9-7, Simultaneous Independent ILS/MLS Approaches; Your Memo Dated June 29, 2009

We have reviewed your request for an interpretation of FAA Order JO 7110.65, Paragraph 5-9-7, Simultaneous Independent ILS/MLS Approaches, and offer the following;

While not specifically stated in Paragraph 5-9-7, standard radar separation must be maintained between two aircraft executing an ILS approach until both of the aircraft are established on the localizer.

Consideration will be given to including the findings of this interpretation in the next change of FAA Order JO 7110.65.

If you have any questions or desire further information, please contact Jay Garver, Procedures Development Group, at (202) 493-5266.

Federal Aviation Administration

Memorandum

Date: JUN 2 0 2013

To: Michael J. McCormick, Director of Terminal Safety & Operations Support

From: Nancy B. Kort, Director of Terminal Operations, Central Service Area

Subject: Request from Motown District for Interpretation of FAA Order 7110.65S, Paragraph 5-9-7: Established on Localizer

Attached is a request from the Acting Manager, Motown District, for an interpretation of FAA Order 7110.65, Paragraph 5-9-7, regarding the requirements for an aircraft to be established on the localizer prior to discontinuance of standard separation (Attachment 1). We request that clarifications or interpretations containing verbiage, not currently reflected in the directive, be incorporated into the appropriate paragraph. We also request that you reply to this memorandum as expeditiously as possible.

If you require additional information or have any questions, please contact Susan Ruddy, Support Specialist, Operations Support Group, ATO Central Service Center, at 817-321-7713.

Attachment

Federal Aviation Administration

Memorandum

Date: June 17, 2009

To: Nancy B. Kort, Director of Terminal Operations, Central Service Area
HIRL – Anthony Roetzel, Group Manager, Operations Support Group

From: Acting Motown District Manager

Subject: Request for Interpretation of FAA Order 7110.65S, Paragraph 5-9-7, Simultaneous Independent ILS/MLS Approaches – Dual and Triple, Established on Localizer

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Detroit Metro TRACON (D21) requests an interpretation of FAA Order 7110.65S, Paragraph 5-9-7, Simultaneous Independent ILS/MLS Approaches – Dual and Triple. The requirements in this paragraph do not specifically require aircraft to be established on the localizer prior to discontinuance of standard radar separation of three miles or 1,000 feet. However, it has been asserted by facility personnel and external sources as a requirement, such as that found in paragraph 5-9-6, Parallel Dependent ILS/MLS Approaches.

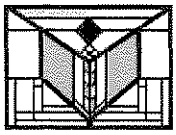
A comparison of paragraphs 5-9-6 and 5-9-7 reveals that several requirements are identical and are specified in both paragraphs. For example, both paragraphs specify a requirement to "provide a minimum of 1,000 feet vertical or a minimum of 3 miles radar separation between aircraft during turn-on to parallel final approach". For parallel dependent approaches an additional requirement provides that minimum separation with the adjacent final approach course is permitted "only after aircraft are established on the parallel final approach course" as stated in paragraph 5-9-6b1.

The difference between application of dependent or independent procedures in this case is that independent approaches provide final monitors, a depicted no transgression zone (NTZ) between final approach courses, and a requirement for one mile of straight flight prior to final approach course intercept. The final monitor may make a correction if the pilot does not correctly intercept and become established on the final approach course. The increased angle and requirements for one mile of straight flight prior to final approach course intercept serve to minimize the risk that the aircraft will fail to intercept the approach course. Paragraph 5-9-7 also speaks to aircraft observed to overshoot the turn-on [illegible] aircraft [illegible] established on the final approach course [illegible]

[illegible] indicate there is no additional requirement for aircraft [illegible] prior to application of minimum separation.

We would like an official interpretation as to whether "established on the localizer" and distinct requirement for applying minimum separation in accordance with paragraph [illegible]. Furthermore, if "established on the localizer" is indeed a requirement in this case, it should be specifically identified in the order, just as it is specified in paragraph [illegible] Dependent ILS/MLS Approaches.

If you have any questions, please contact Support Manager Patricia Hymans at [illegible].



Tim Funari/AGL/FAA
TCL-D21, Detroit TRACON, MI

10/15/2008 10:42 PM

To Earl Grand/AGL/FAA@FAA
cc Thomas Boland/AGL/FAA@FAA
bcc
Subject Probable ODs/OEs

Earl,

As you know, I have deeply held feelings about our selective enforcement of directives/orders. I strongly believe we cannot hold controllers accountable until we set the expectation that they must indeed comply with all directives/orders. This is not currently the case. We have actively contributed to a culture of apathy. I am incredulous, especially since the advent of mandatory audits, that my repeated attempts to shed light on our (management's) failings have been ignored. However, I believe a careful audit of the 09-03-08 7am and 8:30am arrival banks as well as the 9-10-08 7am and 10am arrival banks would reveal multiple deviations and separation errors. The decision to involve myself beyond the purview of my normal duties was a difficult one, especially in light of the repercussions of my previous attempts to bring out into the open the ways in which we are failing to uphold the public trust. As I brace myself for further retaliation, I remain hopeful that this memo will be viewed as compatible with the philosophy of "Leading From Where You Are" but I do not expect it will be.

Tim

Tim Funari/AGL/FAA
TCL-D21, Detroit TRACON, MI

10/16/2008 03:20 PM

To Cliff Auxier/AGL/FAA@FAA
cc Gary F Ancinec/AGL/FAA@FAA, Joseph Figliuolo/AGL/FAA@FAA, Thomas Boland/AGL/FAA@FAA
bcc
Subject Re: Probable errors

All,

1) I became aware of these probable errors through a random, self initiated review of NOP and voice recordings.
2) Although I do not have an exact date, I believe it was within a week after the September FLM meeting. As you are all aware, I have been telling every level of facility management for years that we are selective and arbitrary in the enforcement of agency orders and directives, and that we are experiencing many more incidents than are reported. I have had to make stands against superiors who have, in the most blatant of ways, tried to intimidate and interfere with my efforts to bring light to these issues. I have pointed out that our airspace delegation itself is often insufficient to allow the controller to comply with directives. Mr. Figliuolo asserted in the referenced meeting, that I have been telling him for six years that we are not following our own rules, I believe I have been beating my head against this wall much longer. Sitting in that meeting and hearing Mr. Figliuolo say aloud the significant length of time I have been trying to get us to do what we are supposed to do, then listening to him put it out as a referendum, and noting what ranged from complacency to disdain, with only one FLM (KN) to support me, made a deep impression. I have voiced on many occasions in the past that the best way to test the veracity of my statements is through the audit process. Noting that not a single error or deviation has been revealed in our local audits, and knowing how many times I intervene to prevent errors/deviations, having brought to light specific instances that were not followed up on with an audit, I wanted to see what could/should be revealed if an audit was attempted with a sincere desire to uncover our mistakes. My intent was/is **NOT** to credit any CPC with these errors/deviations. In fact, I strongly believe that until we change a culture that **WE** created they should be facility errors, not individual errors. My intent was and is to do what I can from my position to influence a positive change in this facility by exposing our ineffectual identification of system safety issues, and to bring us into compliance with orders and regulations. I guess I just felt what I had been doing wasn't working, so I am trying something new. The problem is that I truly believe that if a change was desired, it would have happened by now, and that I continue on this path at great personal risk. I am scared and concerned about my and my family's well-being.
3) No one reported the errors to me.
4) Specifics: As I mentioned above I performed an informal audit after our last FLM meeting (I did not note the day or time). I would not know who may have witnessed the errors, other than the individuals involved. Where I omit requested information, it is because I did not make note of it, I am not sure, or I do not know. I do not certify this as a complete list.

09-03: OD: NWA1580, aprox. 1108Z, control instruction in another controller's airspace w/o authorization. (POLAR controller?)
OE: NWA1497, aprox. 11:15Z, lost vertical separation during independent ILS approach while on final frequency
PD/OE possible: NWA335, aprox. 11:17Z, not on tower frequency during independent ILS approach when altitude separation lost
PE: NWA853, aprox. 11:46Z, lost required separation during turn to final during dependent ILS approach
OD: NWA1012, aprox. 11:48Z, enters jet airspace w/o point-out
OD: NWA659, between 12:34Z and 12:46Z, aprox 1,500 above glide slope during intercept
OD & OE possible: MES3514, aprox. 12:49Z, not on tower frequency during independent ILS approach when altitude separation lost,; aprox 500 above glide slope during intercept
OD: N48KR, between 12:48Z and 12:52Z, aprox 1,000 above glide slope during intercept

09-10: OD: FLG5974, aprox. 1143Z, "Y" airspace separation. (CPC:AA)
OD, OD: NWA1720, aprox 1145Z, "Y" airspace separation also joins final inside 4nm final

w/o coordination. There are many issues regarding this acft. and NWA1722 that may result in more error determinations. (CPC:AA)

PD: MES3074, aprox. 1424Z, climbs out of 5,000 into "F" airspace w/o clearance.

OD: NWA1561, aprox. 1425Z, "K" airspace separation, (FLM:BZ)

OE: RPA3393, aprox. 15:01Z, cleared for visual approach w/o RWY or traffic in sight, looses separation with traffic ahead. (FLM:BZ)

OE: CPZ1969, aprox. 15:03Z, not established on a 30 degree intercept for RWY22R prior to loss of separation with NWA215 on RWY22L, application of visual separation by BZ too late. (CPC:TS)

I must note that if Mr. Grand's review, as mentioned below, was consistent with other facility audits, even a partial validation of the observations I noted above would reveal significant problems/limitations of the audit mechanism employed here, rendering them, in my opinion, as to be practically useless.

Finally, a last observation. With regard to the QAR from 09-18-08: what does it say when QA investigates an incident in which an aircraft is not switched to the tower's frequency as required by 7110.65 and does not identify the resultant OD? My belief is that it points to systemic nature of our apathy to the orders under which we are supposed to be operating as well as to our indifference to our obligation to maintain the public trust. Further, the aircraft apparently landed w/o a landing clearance, a PD. The last guidance we received (in the September FLM meeting) is that there is no longer discretion in the reporting of PDs, has this changed? . Lastly, the QAR investigation seems to have the narrowest focus that would be supportable. A thorough investigation would, I am sure, result in the reporting of multiple ODs.

Again, I must stress, we have to make positive and necessary changes that allow the individual to comply with directives/orders, we must elevate our expectations of work force performance to that required by organizational regulations and we must execute our obligations with regard for the public trust. Only then can we hold the individual accountable.

Tim

Cliff Auxier/AGL/FAA

Cliff Auxier/AGL/FAA
TCL-D21, Detroit TRACON, MI

10/16/2008 11:24 AM

To Tim Funari/AGL/FAA@FAA

cc Gary F Ancinec/AGL/FAA@FAA, Thomas Boland/AGL/FAA@FAA, Joseph Figliuolo/AGL/FAA@FAA

Subject Probable errors

The facility has begun a preliminary investigation into the alleged ODs and OEs that you reported to Mr. Grand form 9/3 and 910. Earl has reviewed radar replays from both dates and was not able to discover any facts to support your allegations. The remainder of this e-mail is the start of my investigation into the probable ODs and OE's that you suggest occurred on 9/3 and 9/10.

Please answer the following questions to best of your ability:

1. How did you find out about these probable errors?
2. When did you find out about these probable errors?

3. Who reported these probable errors to you? Provide names, dates and times. If these reports were not first hand knowledge, provide the trail that leads to the person who witnessed the probable errors.
4. Provide specifics about the probable errors:

- Call signs
- Times
- CPC/CPCs having probable errors
- Wittiness to each reported probable error
- Did you investigate the probable errors?
- When did you investigate these probable errors?

As you respond to the following investigation, you are not authorized to use any investigative tools, including voice recording and/or radar replay data, other than data that you may have already accumulated in your files. Any additional use of voice recording and/or radar replay tools to further investigate these probable errors will be managed at the direction of Mr. Figliuolo.

Please resond to all by COB today.

Thanks for your assistance.

cd

Federal Aviation Administration

Memorandum

Date: 10/23/2008

From: Tom Boland III, Operations Manager, Detroit TRACON

To: Tim Funari, Front Line Manager, Detroit TRACON

Subject: EAP Assistance

Tim, if you are facing personal problems and/or are dealing with emotional distress I encourage you to contact the Employee Assistance Program (EAP). The EAP is an employee benefit provided by the FAA and is offered at no cost to you.

I feel that the EAP can provide a valuable resource for support and information. My goal is to fully support you and help you through any difficulties. I will be available to work with you to assure time is allotted for you EAP visit. If you would like, I could even make the appointment on your behalf.

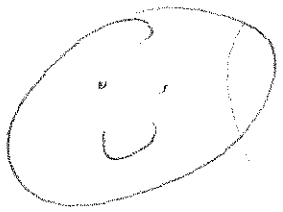
You may talk with an EAP Counselor anytime (24/7) by calling 1-800-234-1EAP.

You are a valued employee. I am available for any assistance that you may need.

Respectfully,

Tom Boland III

Federal Aviation Administration



Memorandum

R&I	4/9/09
PRE-DUTY	Tracon
DURING SHIFT	
GIB	
Remove on	5/7/09
Originator	
Copies to	

Date: April 9, 2009

To: All Personnel

Gary Ameiman

From: Acting Staff Manager, D21

Subject: Coordination

Effective immediately, you must stop using all prearranged coordination that is not published in a facility directive. This includes blanket point outs and asking another controller to delegate part of their airspace to you for a specified period of time.

Please speak to your Front Line Manager or Operations Manager if you have any questions.

DOES THIS INCLUDE SIMO OPS? NO - BZ ats in SOP

BAD WX ROUTING AGREEMENTS? UH OH!

WHAT DOES THIS MEAN!? FLM DON'T KNOW EITHER!

SO CAN I HAVE A HAND-OFF PERSON TO DO ALL THE POINT OUTS ON EVERY ACFT WHEN I AM "A" ON A NORTH FLOW? NO!

BACKGROUND AND PURPOSE PLEASE!

WHAT NEXT!

This is in 7110.65 5-4-10 BZ

Reporting Requirements for Safety Events

In the past few weeks, the FAA has experienced safety events that have revealed some problems with our reporting process.

This briefing item is intended to reinforce the appropriate process and expectation for those events where safety may have been compromised.

The facility ***Quality Assurance Operational Quick Reference Guide***, developed by the DTW Quality Assurance Office, has been revised and is a reference offering specific reporting guidance for most events that you would encounter.

The guide is located in the Quality Assurance Binders and included in all QA envelope packages, and/or can be viewed/downloaded on the "W" Network drive, under DTW ATCT, ALL4AT, Detroit QA Quick Reference Guide.

Some Key Reporting Requirements:

- The Support Manager for QA needs to be notified of all reportable events. A voice mail on Earl's cell or home phone is acceptable, and he will confirm receipt.

- Time Requirements for Completion of Preliminary Reports:

    - Operational Error (Category A, or Surface Error) = 4 hours
    - Operational Error (Category B or C) = next administrative day
    - Operational Deviation = next administrative day
    - Proximity Event = next administrative day
    - Pilot Deviation = 4 hours
    - NMAC = 3 hours
    - Vehicle / Pedestrian Deviation = 3 hours
    - Aircraft Accident = ASAP, but no later than 2 hours
    - Incident Report (e.g., TCAS RA with loss) = 3 hours

- Notification Requirement for Significant Events. For the events highlighted above…**Verbally** notify the ROC ASAP if the event involved an air carrier, commuter, air taxi, a prominent person, or may become newsworthy.

- Immediately after an accident, air traffic incident, security, traffic management, or any significant operational event that might generate significant media or congressional interest, you must notify the ROC!

- For Security Events, facilities must also notify the Domestic Events Network (DEN), following established procedures contained in FAA Order 7610.4, Special Operations.

- When ATC service is provided, facility must conduct a QAR for.....

    - Aircraft Accidents
    - Proximity Events
    - TCAS RA Reports
    - Missed Approaches & Go-Arounds
    - Public Inquiries regarding ATC service
    - Interfacility TMU initiatives causing "No Notice Ground Stops, or Airborne Holding"
    - **Air Traffic Incidents**, excluding OE/OD's

- **Air Traffic Incidents include:**

    - Near Midair Collisions
    - Pilot Deviations
    - Vehicle & Pedestrian Deviations
    - Emergency Evacuations
    - Parachute Jumping Incidents
    - Emergencies (medical, aircraft, etc.)
    - Bomb Threats
    - Flight Assists

- If an initial review of an event indicates an OE or OD, a QAR is not required. Simply indicate on the Daily Operations Log that an OE/D occurred.

- In summary ... If you are ever uncertain whether an event needs to be reported, please do not hesitate to call a manager for guidance.