July 10, 2010

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1730 M Street, NW, Suite 300
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Re: OSC File No. DI-08-3138

Dear Ms. Gorman,

Thank-you for providing the opportunity to comment and for your continued actions in pursuing these matters in the face of what I believe to be a less than thorough OIG investigative ethic and disingenuous agency statements that minimize the malfeasance that is at the heart of my allegations.

As I understand it, you asked OIG for clarification of "the findings with respect to the missed approach procedures." I took that to mean the discussion would be related to the report of investigation. In paragraph two of that response, OIG makes the following assertion with regard to what a Detroit controller does:

> *...although the controller would terminate radar service for the aircraft, he/she would maintain safe separation from other aircraft along the aircraft's projected flight route from the uncontrolled airport to the holding pattern area designated in the missed approach or alternate missed approach procedure.*

This sounds like an assertion that the missed approach route and holding pattern were sterilized; in other words, no other aircraft were allowed to occupy any portion of that airspace. This appears to be materially different from the final report. Given the fact that the same document asserts that they did not monitor satellite airport operations, how can they make this assertion? On what basis did they draw this apparently new conclusion? Is it a finding or did the OIG simply accept at face value the statement of someone in the FAA and present it as theirs? If so, what person provided that input? It would not be the first instance where this appears to be the case and, as I have said before, lends the appearance of bias in favor of the agency. What observations do they have to support this assertion? When they assert the maintenance of "safe separation" are they discussing radar or non-radar separation standards, or both, and which ones specifically? It misleads one into believing that the appropriate separation was being applied, contrary to my first-hand knowledge. Is it meant to convey this? When the safe separation claimed in the statement is applied, it should be through the utilization of a rule or minima authorized by JO 7110.65? What rules/minima were being utilized in providing the separation that is asserted? At what point was the facility compliant, if that is the new conclusion? Was it before, or after, late February 2009, at which point the service area stepped-in to require the facility to apply non-radar separation to separate other aircraft from the missed approach protected airspace? As mentioned in my original comments regarding the

details of the findings for allegation 1, the OIG investigation did not understand and, therefore, did not investigate my allegation. This supplemental report seems to perpetuate that misunderstanding. If the OIG and AOV understood my allegation, they would not be requiring evidence of a loss of separation during the "execution" of a missed approach procedure, and discussions with Mr. Mello and Mr. Dodd would not be centered on an aircraft that is known to be executing a missed approach. They would just verify that aircraft were indeed allowed to transit the protected airspace contrary to JO 7110.65 requirements. I will discuss it in greater detail below but the system event that occurred in the January 17, 2009 incident that I forwarded to Mr. Urega and Mr. Luepker demonstrates the issue. NWA 2434 is descended into the holding pattern airspace that is required to be protected for the missed approach segment of the RNAV (GPS) RWY 9 approach into VLL to which N3845G had earlier been cleared. **Neither communications nor radar contact existed with the VLL arrival**, cancellation had not been received, and the incident occurred within 30 minutes of the time N3845G received its approach clearance. N3845G is what we refer to as an unreported, non-radar arrival. Radar service had been terminated and we don't know where the aircraft actually is at the time NWA is cleared into protected holding pattern airspace. The last we **know** is that the aircraft was headed to VLL with a clearance that authorized it to continue to the missed approach holding point climbing to 2,700 feet. NWA is cleared to descend into the VLL holding pattern without being cleared **through** the altitudes assigned to N3845G (NWA levels at 3,000 feet while N3845G has a clearance from the surface to 2,700 feet). We have a requirement to separate from this unreported aircraft. We do not wait until we know the aircraft has executed a missed approach and then scramble to start separating from it. We don't, for instance, release a departure off of VLL under these circumstances; we wait for a report from the aircraft or comply with the timeframe of the traffic restriction paragraphs of JO 7110.65: 10-4-1 and 10-4-3. Those and a couple of other applicable 7110.65 excerpts follow (highlighted areas are for emphasis):

- **10-3-1. OVERDUE AIRCRAFT**

  a. Consider an aircraft to be overdue, initiate the procedures stated in this section and issue an ALNOT when neither communications nor radar contact can be established and 30 minutes have passed since:

  NOTE

  The procedures in this section also apply to an aircraft referred to as "missing" or "unreported."

  1. Its ETA over a specified or compulsory reporting point or at a clearance limit in your area.

  2. Its clearance void time.

  b. If you have reason to believe that an aircraft is overdue prior to 30 minutes, take the appropriate

action immediately.

c. The center in whose area the aircraft is first unreported or overdue will make these determinations and takes any subsequent action required.

- **10-4-1. TRAFFIC RESTRICTIONS**

IFR traffic which could be affected by an overdue or unreported aircraft shall be restricted or suspended unless radar separation is used. The facility responsible shall restrict or suspend IFR traffic for a period of 30 minutes following the applicable time listed in subparas a thru e:

a. The time at which approach clearance was delivered to the pilot.

b. The EFC time delivered to the pilot.

c. The arrival time over the NAVAID serving the destination airport.

d. The current estimate, either the control facility's or the pilot's, whichever is later, at:

1. The appropriate en route NAVAID or fix, and

2. The NAVAID serving the destination airport.

e. The release time and, if issued, the clearance void time.

- **10-4-3. TRAFFIC RESUMPTION**

After the 30-minute traffic suspension period has expired, resume normal air traffic control if the operators or pilots of other aircraft concur. This concurrence must be maintained for a period of 30 minutes after the suspension period has expired.

- **5-3-1. APPLICATION**

Before you provide radar service, establish and maintain radar identification of the aircraft involved,

except as provided in para 5-5-1, Application, subparas b2 and 3.

- **5-5-1. APPLICATION**

b. Radar separation may be applied between:

1. Radar identified aircraft.

2. An aircraft taking off and another radar identified aircraft when the aircraft taking off will be radar-identified within 1 mile of the runway end.

3. A radar-identified aircraft and one not radar-identified when either is cleared to climb/ descend through the altitude of the other provided:

(a) The performance of the radar system is adequate and, as a minimum, primary radar targets or ASR-9/Full Digital Radar Primary Symbol targets are being displayed on the display being used within the airspace within which radar separation is being applied; and

(b) Flight data on the aircraft not radar identified indicate it is a type which can be expected to give adequate primary/ASR-9/Full Digital Radar Primary Symbol return in the area where separation is applied; and

(c) The airspace within which radar separation is applied is not less than the following number of miles from the edge of the radar display:

(1) When less than 40 miles from the antenna- *6 miles;*

(2) When 40 miles or more from the antenna- *10 miles*;

(3) Narrowband radar operations- *10_miles;* and

(d) Radar separation is maintained between the radar-identified aircraft and all observed primary, ASR-9/Full Digital Radar Primary Symbol, and secondary radar targets until nonradar separation is established from the aircraft not radar identified; and

(e) When the aircraft involved are on the same relative heading, the radar-identified aircraft is vectored a sufficient distance from the route of the aircraft not radar identified to assure the targets are not superimposed prior to issuing the clearance to climb/descend.

- RADAR APPROACH CONTROL FACILITY- A terminal ATC facility that uses radar and nonradar capabilities to provide approach control services to aircraft arriving, departing, or transiting airspace controlled by the facility.

- RADAR ARRIVAL- An aircraft arriving at an airport served by a radar facility and in radar contact with the facility.

- **c.** Nonradar Arrival. An aircraft arriving at an airport without radar service or at an airport served by a radar facility and radar contact has not been established or has been terminated due to a lack of radar service to the airport.

- ***RADAR SERVICE TERMINATED-***

Used by ATC to inform a pilot that he/she will no longer be provided any of the services that could be received while in radar contact. Radar service is automatically terminated, and the pilot is not advised in the

following cases:

a. An aircraft cancels its IFR flight plan, except within Class B airspace, Class C airspace, a TRSA, or where Basic Radar service is provided.

b. An aircraft conducting an instrument, visual, or contact approach has landed or has been instructed to change to advisory frequency.

c. An arriving VFR aircraft, receiving radar service to a tower-controlled airport within Class B airspace, Class C airspace, a TRSA, or where sequencing service is provided, has landed; or to all other airports, is instructed to change to tower or advisory frequency.

d. An aircraft completes a radar approach.

e. Nonradar Separation. The spacing of aircraft in accordance with established minima without the use of radar; e.g., vertical, lateral, or longitudinal separation.

- NONRADAR SEPARATION [ICAO]-

The separation used when aircraft position information is derived from sources other than radar.

- RADAR SERVICE- A term which encompasses one or more of the following services based on the use of radar which can be provided by a controller to a pilot of a radar identified aircraft.

a. Radar Monitoring- The radar flight-following of aircraft, whose primary navigation is being performed by the pilot, to observe and note deviations from its authorized flight path, airway, or route. When being applied specifically to radar monitoring of instrument approaches; i.e., with precision

approach radar (PAR) or radar monitoring of simultaneous ILS/MLS approaches, it includes advice and instructions whenever an aircraft nears or exceeds the prescribed PAR safety limit or simultaneous ILS/MLS no transgression zone.
(See ADDITIONAL SERVICES.)
(See TRAFFIC ADVISORIES.)

b. Radar Navigational Guidance- Vectoring aircraft to provide course guidance.

c. Radar Separation- Radar spacing of aircraft in accordance with established minima.
(See ICAO term RADAR SERVICE.)

- RADAR SERVICE [ICAO]- Term used to indicate a service provided directly by means of radar.

a. Monitoring- The use of radar for the purpose of providing aircraft with information and advice relative to significant deviations from nominal flight path.

b. Separation- The separation used when aircraft position information is derived from radar sources.

What I have said regarding the alternate missed approach procedure at Monroe Custer (TTF), which is the preferred procedure when Detroit Metropolitan is landing to the north, is that when we lose radar and communications on the aircraft cleared for that approach (a now unreported, non-radar aircraft) we continue to vector traffic through the missed approach route of flight and holding pattern contrary to JO 7110.65 requirements. The holding pattern is on the final approach course of two Detroit City (DET) approaches as well as being in close proximity to the Windsor Airport and its instrument procedures. So we have an unreported aircraft and we are not taking steps to separate from this aircraft as required. Remember, the ability to use radar separation between a radar identified aircraft and one not radar identified is limited in such a way as to be inapplicable when aircraft are assigned the same altitude(s) and problematic at best in the vicinity of airports (one is required to separate from all observed primary and secondary radar targets of which there are usually several in the vicinity of airports, and, moreover, are likely to pop up at any time; also, a busy controller can quite easily overlook targets, especially primary returns). I have pointed out this TTF and the Troy Oakland VOR approach as the most blatant examples of non-compliance, not the only examples. I have also discussed the fact that many approaches take the aircraft to a common missed approach holding point and that controllers have simultaneously cleared aircraft for

approaches where the missed approach segment does so. The truth is that concern about impact to efficiency impacts the willingness to understand/fulfill requirements and we have not been given the training to properly separate the aircraft. Every time we have an unreported aircraft and do not apply the procedures I noted above, we have not separated aircraft as required, we have not reported the system event, and we have compromised safety.

OIG goes on to discuss the April 21, 2010 interpretation regarding alternate missed approach instructions and "protected" airspace for the missed approach segment of an instrument approach clearance. At the risk of editorializing, recent interpretations have been less than responsive to the questions asked. In several instances, as with my ongoing safety concerns with the waiver of approximately 30 percent of the separation required for triple simultaneous approaches (another serious safety concern I am trying to pursue in the face of decisions which appear to have been inappropriately impacted by "customer" pressure and efficiency concerns), these interpretations conflict within themselves and with the 7110.65. This seems to be the problem in the immediate case. With respect, they just seem a bit misinformed. I'll put off a detailed discussion of the first issue addressed, that of alternate instructions, for a later date and simply state that it appears to be in confliction with the 7110.65, that the questions were unnecessary to begin with as the original interpretation and the 7110.65 provide sufficient clarification, and that the interpretation neatly sidesteps and is unresponsive to the third question asked. Regarding the second issue discussed in the interpretation, that of protected airspace: although the interpretation acknowledges that the missed approach procedure incorporates "protected airspace throughout the missed approach procedure and at the designated holding pattern," it states that the controller **(the only person in a position to protect the protected airspace),** has no specific requirement to do so. This is in confliction with the specific requirements included above (JO 7110.65: 10-3-1, 10-4-1, 10-4-3 in consideration of 5-3-1 and 5-5-1). The interpretation seems to be saying that the controller will take action to separate aircraft, not when an aircraft is unreported, but only when she/he becomes aware that a missed approach is actually occurring, then scramble to move aircraft out of the way. An interpretation should not conflict with the clear, written, directive; this one appears to do so. In doing so, it removes one more layer of safety in preference to efficiency.

The discussion with Mr. Dodd seems to perpetuate this confliction as well as the misunderstanding of my allegation. The discussion with him appears to surround a known missed approach ("Dodd advised that in the event of a missed approach…") without clarifying requirements for separation from what would have been the unreported aircraft prior to knowledge of the missed approach. Is he actually claiming that what drives the need to suspend traffic is a subjective determination of the likelihood of a loss of separation that is based on the number of aircraft involved and not JO 7110.65 requirements? This may sound like a facetious question, but it is not. The statement that "Detroit TRACON controllers are prepared to apply FAA air traffic procedures to ensure safe separation" is untrue as regards the immediate issue. Based on what information does he make that claim? Is he relying on the certifications that were falsified regarding non-radar training at Detroit TRACON? How was it determined that Mr. Dodd is in the

position to provide accurate information in this regard? Is he involved in any way in training at Detroit? The original OIG report itself, although apparently failing to look into the falsified training certifications, validated the error of this statement by determining that "Frontline Managers we interviewed did not demonstrate adequate knowledge of requirements for separating non-radar aircraft from radar identified aircraft." If the people who certified controller non-radar training do not have adequate knowledge of the requirements, why would we expect a different level of knowledge from the controllers? Is the OIG accepting at face value the veracity of this statement and offering it as some type of valid finding? Did they conduct any interviews with controllers to test it? How many controllers or frontline managers accurately described the requirements for separating a radar identified aircraft from a non-radar identified aircraft? I am not aware of the specifics of how other OIG investigations were executed, but this one seems to be biased in favor of disingenuous statements by the FAA without verifying their veracity. From my perspective, it makes a sham of the investigation.

The fact that OIG did not monitor satellite operations "upon learning from TRACON managers that missed approaches rarely occur" should be troubling to you for a couple of reasons: first, and again, the actual occurrence of a missed approach is not related to my allegation and provides continued proof that the OIG and AOV did not understand my concerns. Monitoring those operations would have shown whether, even after the service area's direction, the appropriate airspace was being protected (that is the importance of the January 17 event which, through incompetence or negligence, was not reviewed). Secondly, notwithstanding their failure to understand the issue, do I understand correctly that this investigation took, once again, at face value the statements of the individuals in FAA management that I allege are purposely not following our regulations and who have admitted this themselves? Does any reasonable person believe that this indicates an objective investigation? My statements are not taken at face value. I am trying to prove them true in the face of agency interference and negligence which has resulted in repeated instances of destruction of documents, among other things. Why are the statements of individuals that I assert are not fulfilling the public trust being given more credence then my own?

Subsequent to my appointment as Support Manager, my access to voice and radar data was removed. It took me a bit of time to get it reinstated (access to voice data only recently so. Does this throw up any alarm bells?). In response to Mr. Urega's inquiry as to the status of compliance at the facility, I forwarded to the OIG and AOV an instance that demonstrated a failure to protect the missed approach procedure of an unreported aircraft at VLL. I forwarded this to them 4 days after the event. As I mentioned above, it was an event from 01-17-2009 (ZULU date) and involved NWA2434 and N3845G. Alarmingly, the OIG now admits that it misled you with regard to the status of the investigation into that incident. Specifically, although the original report states: "AOV is reviewing the data from this event" they now admit that AOV did not even request the voice data for the incident until February 22, 2010, more than a month from the day I had notified them of the event, and the same date of the final report of investigation. Why was it not pursued earlier and included in the final report? They had plenty of time to do so. What data was AOV reviewing then, if it did not possess the voice data? Was it the

radar data? If so, that data in itself should have been enough to conclude that NWA descended through the protected airspace of the VLL missed approach holding pattern. In conjunction with the flight progress strip, the investigation should have shown the descent was before the IFR cancellation of the VLL arrival, an unreported aircraft. Bottom line, OIG and AOV had the specifics of the incident on 01-22-2010 (I include a copy of the e-mail I sent), did not even make a request for the voice data until the date of the final report, then misled you by indicating that data it did not possess was being reviewed. We would have heard no more about it had you not inquired.

Unfortunately, this is not the first time I have been told the data has been destroyed. It is not simply incompetence. It has been repeated within and without of the facility on numerous occasions; some documented in the safety report attached to the follow-up OIG document. Exactly when does accountability catch up to these failures? Was the individual that failed to provide the data aware of, or involved in the March 30, 2009 ATO-Safety investigation or reporting in any way? Did she make any statements about that investigation/report that revealed any bias? What is the name of this individual? Did she apply for any positions at DTW or D21 for which she was not selected? Given the scenario described, and absent intent, failure to properly maintain priorities, not workload, would be a more reasonable conclusion, although a still indefensible one. With a 45-day certain deadline, any less critical actions that were accomplished in the interim would point to an inexcusable negligence given the level of visibility that is sure to be the result. Was this aspect investigated? This OIG follow-up investigative report contradicts itself claiming that "she did not treat AOV's data request differently from previous requests from other sources," while coincidentally noting that she had not failed to retrieve the data in the past. Is that not treating the request differently in a very basic and very important way? **Is the OIG trying to say that fulfilling the request and not fulfilling the request are similar treatments of the request?** To me, it seems like an attempt to marginalize the significance of the failure. What is unsaid in the report is why it took AOV 32 days to make the data request in the first place. What does it say about the priority that the OIG and AOV put on substantiating my allegation? Instead, even though my January 22 e-mail was very clear as to the issue, they still do not accurately grasp the issue, they fail to review the incident I provided, mislead your office and misrepresent my concerns in the final report, noting: "...we have not received, nor did we find, any other information demonstrating a loss of separation during the execution of a missed approach procedure."

My understanding (communicated by the Service Area OSG in the person of John Crawford) was that the service area had directed the facility to retain all radar and voice data indefinitely. This was in place, to the best of my knowledge, at the time of my OIG interview in late 2009. When did that direction change? When did the service area remove this restriction? Did the OIG think it was not prudent to continue the restriction, given the earlier destruction of data in opposition to national orders?

Although the OIG provided the body of the March 30, 2009 ATO-Safety report which references the "CSAG report" from the "Quality Control Review (QCR) at D21 during the weeks of February 9 and 16, 2009; the QCR itself and a "Clarification Email" that

were part of the report as attachments were not provided. Why is that? Are not attachments normally considered a part of the report, especially when they are referenced in the body of the report? I have made repeated requests for a copy of that report, dating to the first week of the review to no avail. Apparently, the agency is still withholding that report.

A few observations on the ATO safety report:

- It was conducted approximately a month and a half after the Service Area investigation, the "CSAG report" being the product of that investigation. Again said report was listed as an attachment to the ATO Office of Safety report, the OIG failed to provide it. It was conducted to "validate the CSAG observations and determine effectiveness of facility actions to-date addressing identified issues." It was conducted **after** the Service Area intervened and directed the facility to correct the longstanding issues that were ignored during the years I attempted to get them addressed. In several areas corrections were already imposed on the facility managers by the Service Area Director.
- With regard to Focus Area 1:
    - In Focus Area 1: Safety Culture Around Event Reporting, it quotes the CSAG report in noting that an Operations Manager, a second level manager responsible for establishing expectations and evaluating the performance of Frontline Managers, as stating that there "is good cheating and bad cheating." Who was that manager? It goes on to say that the CSAG "concluded that the D21 management team had given its 'tacit approval' to these views."
        - First of all, a second level manager, responsible for establishing expectations for the individuals that manage the performance of the controller workforce, is identified as advocating not following orders and directives; rather, he is advocating a subjective application dependant on what an individual feels is good or bad. This is called selective enforcement and results in a state of apathy and non-compliance which, in turn, results in unreported events. Did either CSAG or ATO Safety quantify what this operations manager subjective opinion of good cheating was, and to what rules it was applied? Did OIG follow-up in this regard? This speaks directly to my allegations and seems to have been ignored by OIG in their report (to be sure much else was ignored, such as the specific instances I provided of operations managers failure to report errors and deviations with demonstrated knowledge of the events). If this was the same operations manager who conducted the runway occupancy time study, that statement alone should have supported an independent re-evaluation of the study (see my original comments with regard to allegation 6 of the OIG final report). Operations managers who brand whistleblowers as "squealers" and advocate "cheating" are establishing practical expectations that result in controllers and frontline managers not reporting errors and deviations unless they are ugly. Again, the

CSAG investigation's Certified Professional Controller (CPC) quote demonstrates apathy towards our reporting requirements: "if an event was not that serious, then it doesn't need to be reported," and is just another way of saying: we don't investigate/report it, unless it's ugly; a logical result of OM Boland's direction to me and apparently others which the OIG report fails to substantiate. It results, as the CSAG investigation apparently revealed and as demonstrated above, in controllers accepting the operations manager's assertion that "the sky is green" when the FAA itself is saying "the sky is blue.

- Second, The CSAG documents a culture where "the management team had given it's tacit approval..." to views expressed by controllers and at least one operations manager that condoned not reporting system events as required as well as the selective enforcement of orders and directives. Yet in its final report, while acknowledging the failure to report errors and deviations, the OIG investigator makes the following statements with regard to Allegation 7: "However, the evidence does not indicate that **TRACON officials have purposely failed to** detect, **report, investigate, and address operational errors or discourage employees from reporting such events"** and "**The evidence does not substantiate the existence of a culture** within the Detroit TRACON **that does not** allow or **support the reporting of air traffic events such as operational errors or deviations** or discourages air traffic control staff from reporting such events. (emphasis added)" Notwithstanding the fact that I provided the OIG documentation of specific instances where this was the case, the CPC 'misperceptions taken from the CSAG report are included on page 20 of the final report. It appears, however, in a section where the discussion is disconnected from the meaningfulness of the quote: the Quality Assurance Review Process. Otherwise, it is ignored as relates to my allegations with regard to the reporting culture of the facility, and the final report concludes the "process within Detroit Metro failed to adequately detect and investigate operational errors and deviations." As I mentioned in my original comments, this is an obvious ploy in the face of the numerous, and now documented, instances of failure to report in order to absolve management of accountability/culpability while placing the blame elsewhere. While I know the approval was more than tacit at the highest levels of management, **approval, whether tacit or otherwise, is approval.** Tacit approval is a form of approval that is not expressed clearly, in words. It is approval that is implied by other statements, actions or by a failure to clearly express disapproval with the situation, performance, idea, plan or request (Authoring e-mails that support the reporting of all operational errors and

deviations, for instance, while doing nothing to verify my assertions that we were not so doing). Tacit approval may be expressed by body language such as smiling, a nod of the head, a pat on the back or a shrug of the shoulders, or by ignoring and/or suppressing repeated attempts over the course of years to address the non-compliance. It can be a friendly form of encouragement and support. On the other hand it is approval that can be easily and conveniently denied as/if a situation deteriorates, as in what is going on here. **The OIG seems to ignore the CSAG investigative finding as would be applicable to the reporting culture and management's malfeasance in approving the failure to report, and authors a finding in opposition to it, why?**

- Third, an operations manager is a second level manager. His advocating of the position that any "cheating" (defined by Merriam-Webster's Online Dictionary as: to violate rules dishonestly) is good, is more than tacit approval. As defined by Merriam-Webster, tacit means: implied or indicated (as by an act or by silence) but not actually expressed. This OM expressed approval of not following all the rules, all the time. That provides license to the CPC workforce to follow the informal standard of the OM and not the formal standard of the orders and directives. This results in: the practice of selective enforcement which is a serious management breach of the public trust; a culture of apathy and non-compliance; and is proven to have disastrous consequences to safety (see Darker Shades of Blue: A Case Study of Failed Leadership which was required Mowtown District training at the same time all of this selective enforcement was going ongoing). Why was this overt approval of an influential second level manager not addressed in any report? Is not the agency now displaying the same failure of leadership?

- The ATO Safety report then goes on to document further what CSAG had already documented, the facility was not identifying and reporting system events. Remember, although ATO-Safety is knowledgeable of ATC rules and regulations regarding separation standards, they are not experts in the intricacies of D21 airspace. It is surely to be the case that additional unreported errors and deviations were not identified, even after ATO-Safety review, due to this lack of local expertise. Interestingly, when conducting this investigation, they only carved out 45 minutes at the **end** of their next to last day to interview myself, and did not take me up on my offer to review data with them. I had to push past their objections for a second meeting in order to provide explanation in addition to documentation/examples in response to questions from that first, short meeting (see attached e-mail string). I do not understand this refusal to better include the expertise of the

individual exposing the problem as it is investigated. Do you? Also, there appears to be a contradiction in the ATO-Safety document. On page 2 they suggest that system events were found in a review of mandatory audits while, on page 6, after documenting the destruction of data (is anyone as frustrated and appalled as I am with the repetition of that theme?), they state they did not detect any unreported events in the required monthly audits. Perhaps they are talking about different required audits. In any case, my firm belief, based on past experience with their SAG Service Area counterpart, is that had they included me in the review, more events would have been detected and reported.

- With regard to Focus Area 2: What I alleged in this regard was not an inadequacy in the QAR process itself. Rather, I demonstrated/documented, by reviewing QARs that did not identify performance issues, that not only was the frontline manager not documenting the performance issues the event revealed, he was, moreover, not reporting the operational errors and deviations that a review of the event showed. This was not due to a problem with the process. It was due to the failure of management to execute their duties with regard for the public trust. The "process" was not the cause of the failure, the frontline manager failed to report the event (see my original comments). It is perhaps instructive to note that a QAR by Mr. Carl Burton, then a frontline manager, was one of the events where I showed that the QAR should have resulted in his identification of an operational deviation, but did not. Further, the QAR determined no controller deficiencies what-so-ever. Mr. Burton, now a contract employee charged with reviewing QAR events, now identifies numerous errors and deviations, when as a frontline manager, he identified virtually none. The change is not due to a change in the QAR process; it is due the fact that he is no longer responsible for the performance of the employee whose actions he is investigating and no longer responsible for managing that performance to reduce system events; therefore he is now more likely to report them. Although I do not include the instances here, they were provided to the Service Area and OIG/AOV.

- With regard to Focus Area 3:
  - As with the OIG final report, the finding is that there is a five-mile requirement, the reason for which apparently no one quite understands, but that it is not consistently applied, yet is silent on the resultant errors and deviations. Why? Should they not know what is required and when? As with the OIG report, it is also silent on the issue of the facilities failure to address the issue over the years I have been highlighting it. Even now, after several attempts, my recommendations to put in place the correct procedures have not been supported. I have simply been told to, again, provide those recommendations.

- In the discussion surrounding the missed approach procedure for VLL, the ATO-Safety report notes that "Facility management maintains that since radar coverage exists to the surface at VLL that there is no need to protect PTK traffic through non-radar procedures from the VLL arrival and potential missed approach." A few serious concerns here:
  - First and foremost, the radar coverage at VLL does not extend to the ground. For facility management to claim otherwise is incorrect and, in the context of the importance of the investigation, is negligent or purposefully misleading. Who communicated this easily proved falsehood? Why did ATO-Safety accept it at face value? They suggest that they made "observations;" were those of radar coverage not included? Even if coverage had existed to the ground, how does that absolve the controller from separating from the unreported aircraft, whose radar services have been terminated once radar and communications are lost?
  - Secondly, the ATO-Safety investigation seems to have a bit of a better understanding of the issue as I have communicated it. The OIG and AOV obviously had access to this and, I believe, the CSAG investigation findings. Why do they not demonstrate a similar understanding of my allegation?
  - Lastly, ATO-Safety recommendation is far different from Mr. Mello and Mr. Dodd's suggestion/guidance that the controller protects nothing then scrambles to separate aircraft when it is known the missed approach has occurred. Why did the OIG ignore this?

- With regard to Focus Area 4: ATO-Safety asserts that it "did not observe the use of 'look and go' by D21 personnel as alleged by the FLM." I had demonstrated that airspace boundary separation was not being maintained in all cases. Although not discussed in the report, ATO-Safety was, I believe, aware of this. Any time boundary separation is not maintained as required, "look and go" is being utilized. Further, I had provided to the team, in that second meeting that they were hesitant to grant (04/02/2009), several time periods that were within the 45-day retention period and one that was contemporary with there visit that would have documented a more blatant form of just such an unauthorized operation. The dates and times were: 04/01/2009 @ 0141:15Z, "E" position with "S"; 03/22/2009 @ 1601Z, "W" position with "S" and 02/21/2009 @ 1719Z, C2 with "Y." Was the data from these timeframes reviewed? It could not have been, otherwise the ATO-Safety finding would have substantiated my allegation. Why wasn't it reviewed? Has this data also been destroyed? On 04/01/2009 for example, the East Jet Departure controller called the West Feeder position and said: "Hey, I'm going to turn these guys early reference any traffic you have in the dump zone. Is that O.K. with you?" Individual point-outs, were required in the absence of a facility directive authorizing Prearranged Coordination; every instance where this was not accomplished would be an operational deviation. I do not recall any operational deviations reported for this type of unauthorized prearranged coordination by either ATO-Safety or, for that matter, by the Service

Area (even though the Service Area did substantiate my allegation. That substantiation should be in the report that the OIG failed to include. I can provide a document that alludes to it being a finding of the report if you like.)

- With regard to Focus Issue 5, Additional Issue 'straight and level:' My allegation was that controllers were routinely not complying with the requirement and, given the totality of the pertinent orders, these lapses are either an operational deviation or error, dependant on the closest distance between the aircraft that results. It seems to me that a semantic argument is being made to say that nine deviations/errors in an hour that may have include sixty-some arrivals on the high end, is not "consistent misapplication." What I find interesting is that there is no discussion of the errors or deviations that should have been the result of these non-compliance events.

Sincerely,

Timothy M. Funari

Attachment 1: Side 1, E-mail string on Service Area direction; Side 2, e-mail to OIG/AOV regarding 01/17/2009 incident

Attachment 2: "Darker Shades of Blue: A Case Study of Failed Leadership

Attachment 3: E-mail string for follow-up meeting with ATO-Safety

Joseph FigHuolo/AGL/FAA

02/25/2009 08:18 AM EST

To Tim Funari/AGL/FAA@FAA
cc Thomas Boland/AGL/FAA@FAA, Cliff Auxier/AGL/FAA@FAA, David Ausherman/ASW/FAA@FAA
bcc
Subject Re: ACTION: KN action on VLL approaches and other

Tom and/or Cliff,

Please brief Tim ASAP.

Thanks,

Joe
Tim Funari/AGL/FAA

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

02/25/2009 07:33 AM

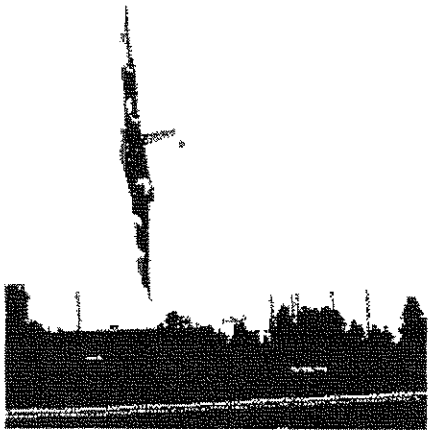
To thomas.boland@faa.gov
cc joseph.figliuolo@faa.gov
Subject ACTION: KN action on VLL approaches and other

Mr. Boland,

Tom says that, based upon info provided by Mr. Auxier' he briefed his crew that the VOR approach at VLL shuts down PTK arrivals and departures. He mentioned other changes that he briefed as a result of the ATO Safety audit. I have not seen any communication on this but want to get my crew up-to-date. Can someone provide me the info I need to do so?

Tim

Neil Krey's CRM Developers



Darker Shades of Blue:

A Case Study of Failed Leadership

By

Major Tony Kern
United States Air Force

Author's Preface

When leadership fails and a command climate breaks down, tragic things can happen. This is the story of failed leadership and a command climate which had degenerated into an unhealthy state of apathy and non-compliance--a state which contributed to the tragic crash of a B-52 at Fairchild Air Force Base, on the 24th of June, 1994, killing all aboard.

I have three purposes with this case study. First, I hope to integrate the various elements of the story into a historically accurate and readable case study for all interested parties, to provide a clearer picture of what actually occurred at Fairchild Air Force Base in the years and months leading up to the tragedy. Secondly, I wish to analyze leadership and the command climate at the wing, operations group, and squadron levels. This analysis will identify possible errors and provide lessons learned, for use in academic environments. Finally, I wish to show the positive side of this episode, for there were many who did the right thing, and acted in a timely and proactive manner. Their actions might well have averted the disaster in a more rational command climate. Their story should be told.

All testimony contained in this report are taken from the AFR 110-14 *Aircraft Accident Investigation Board* transcripts, obtained through the Freedom of Information Act, or through personal interviews conducted by the author. I analyzed transcripts from 49 individual testimonies, and conducted 11 personal interviews. I wish to make it perfectly clear, that no data was taken from the *Air Force* ***Safety*** *Mishap Investigation,* so the issue of *privilege* was not a factor in preparing this report. In fact, I intentionally did not read or receive a briefing on the results of the safety board for the express purpose of avoiding even the appearance of a conflict.

Placing blame on individuals was not my intention and is not the purpose of this monograph. However,

my interpretation of events found potentially significant errors in leadership, disregard for regulations, and breeches of air discipline at multiple levels. As an officer and aviator, I found many of these events personally and professionally appalling. Occasionally, my interpretation of events reflects this mood. Although I have attempted to avoid bias, I make no apologies for my discoveries. Any errors of omission or commission are strictly those of the author. I write this as my contribution to promoting the Air Force values of integrity, fairness, discipline, and teamwork-- all found to be tragically lacking in this example.

Format

Because it is envisioned that this case study may be used in academic settings, the format includes certain features that will lend themselves to effective instruction. Key concepts and terms appear in boldface, and are discussed in summary at the end of the monograph. Additionally, hypothetical questions are posed to spur thought and facilitate discussion. The companion "Instructor Guide" is designed for use to a generic Air Force audience and may be modified in any manner to suit effective instruction.

I have documented this case study through the extensive use of informational endnotes and traditional citation endnotes. However, to preclude breaking up the narrative with endless citations (I could have literally footnoted almost every line of the monograph), I have often placed a single citation at the end of a group of testimony or statements which came from the same source, in an effort to improve on the readability of the document. I beg the academic purists' indulgence in this matter.

As a final note, I have copyrighted this case study not to inhibit its use or dispersion among military personnel,--but to prevent portions of the study being quoted out of context to cast negative light on the Air Force or its personnel. This foreword provides blanket approval for military personnel to duplicate this case study *in total (cover to cover). I must emphasize again that I do not wish individual segments to be isolated and taken out of context.*

Prologue

"What's the deal with *this* guy?" Captain Bill Kramer asked, indicating a car conspicuously parked in the center of the red-curbed "No Parking" zone adjacent to the wing headquarters building. It was a short walk from the HQ building, commonly referred to as *The White House,* to the parking lot where they had left their own vehicles while attending the briefing on the upcoming airshow. As they passed the illegally-parked car and then the various "reserved" spaces for the wing and operations group commanders, Lt Col Winslow turned to Captain Kramer, and replied, "That's Bud's car. He always parks there." After a few more steps the Captain inquired, "How does he get away with that?" The Lieutenant Colonel reflected for a moment and responded, "I don't know--he just does." [1]

Section One: Introduction

There are no bad regiments, only bad colonels.

Napoleon

Failed leadership can have tragic consequences. In the words of Major General (Retired) Perry Smith, a career Air Force aviator and former commandant of the National War College, "Leaders make a difference, and large and complex organizations (like an Air Force Wing) make special demands on the men and women who run them." [2] This is the story of a group of leaders who did not meet all the demands required to establish a healthy command climate, and when confronted with evidence of regulatory deviations- and poor airmanship, did not take appropriate disciplinary actions. There were several manifestations of these failings. Only the most tragic and dramatic is addressed here--the crash of Czar 52. An examination and analysis of the command climate which existed at Fairchild AFB in the three years preceding the crash illustrates several examples of failed leadership relating to a series of breeches of air discipline on the part of a senior wing aviator, Lt Col "Bud" Holland, the pilot in command of Czar 52.

On the 24th of June 1994, *Czar 52,* a B-52H assigned to the 325th Bomb Squadron, 92d Bomb Wing, Fairchild Air Force Base, WA, launched at approximate 1358 hours Pacific Daylight Time (PDT), to practice maneuvers for an upcoming airshow. The aircrew had the planned and briefed a profile, *through the Wing Commander level,* that grossly exceeded aircraft and regulatory limitations. Upon preparing to land at the end of the practice airshow profile, the crew was required to execute a "go-around" or missed approach because of another aircraft on the runway. At mid-field, Czar 52 began a tight 360 degree left turn around the control tower at only 250 feet altitude above ground level (AGL). Approximately three quarters of the way through the turn, the aircraft banked past 90 degrees, stalled, clipped a power line with the left wing and crashed. Impact occurred at approximately 1416 hours PDT. There were no survivors out of a crew of four field grade officers. [3]

Killed in the crash were Lt Col Arthur "Bud" Holland, the Chief of the 92d Bomb Wing Standardization and Evaluation branch. Lt Col Holland, an instructor pilot, was designated as the aircraft commander and was undoubtedly flying the aircraft at the time of the accident. [4] The copilot was Lt Col Mark McGeehan, also an instructor pilot and the 325th Bomb Squadron (BMS) Commander. There is a great deal of evidence that suggests considerable animosity existed between the two pilots who were at the controls of *Czar 52.*.

This was a result of Lt Col McGeehan's unsuccessful efforts to have Bud Holland "grounded" for what he perceived as numerous and flagrant violations of air discipline while flying with 325th BMS aircrews. Colonel Robert Wolff was the Vice Wing Commander and was added to the flying schedule as a safety observer by Col Brooks, the Wing Commander, on the morning of the mishap. This was to be Col Wolff's "fini flight," an Air Force tradition where an aviator is hosed down following his last flight in an aircraft. Upon landing, Col Wolff was to be met on the flightline by his wife and friends for a champagne toast to a successful flying career. The radar navigator position was filled by Lt Col Ken Huston, the 325th BMS Operations Officer.

While all aircraft accidents that result in loss of life are tragic, those that could have been prevented are especially so. The crash of Czar 52 was primarily the result of actions taken by a singularly outstanding ***"stick and rudder pilot,"*** but one who, ironically, practiced incredibly poor ***airmanship***. The distinction between these two similar sounding roles will be made clear as we progress in this analysis. Of equal or greater significance, was the fact that supervision and leadership facilitated the accident through failed policies of ***selective enforcement*** of regulations, as well as failing to heed the desperate warning signals raised by peers and subordinates over a period of three years prior to the accident. At the time of the accident, there was considerable evidence of Lt Col Holland's poor airmanship spanning a period of over three years.

Significance of the Case Study

The Fairchild example is worth our further analysis and contemplation, not because it was a unique aberration from what occurs in other military organizations, but rather because it is a compilation of tendencies that are seen throughout the spectrum of our operations. Many aviators report that rules and regulations are "bent" on occasion, and some individuals seem to be *"Teflon coated"* because their mistakes are ignored or overlooked by their supervisors. Most honest flyers will readily admit to operating under different sets of rules depending on the nature of the mission they are about to fly. For example, standard training missions are treated differently than evaluations. Likewise, higher headquarters directed missions are treated differently than inspections, or airshow demonstrations. This often leads to a confusing mental state for young or inexperienced flyers, who see ever-increasing "shades of gray" creeping into their decision-making process. This case study illustrates examples of such missions, and of aviators who felt that the rules were different for them.

Methodology

This monograph takes a case study approach to identify positive and negative aspects of leadership. This study uses no formal definition of leadership, although there are many to choose from. This is not an oversight, but rather by design, to allow each reader the opportunity to apply his or her own notions of leadership to the case study. Leadership assessment will use criterion taken from several sources, chosen for their relevance and practicality, including Major General Perry Smith's "Taking Charge: A Practical Guide for Leaders", "The Leadership Secrets of Attila the Hun", by William Roberts, "Follow Me: The Human Element of Leadership", and "Follow Me II", by Major General (Retired) Aubrey S. Newman, and J. K. Van Fleet's "The 22 Biggest Mistakes Managers Make". In addition, the author selected several points from a lecture given by Lieutenant General (Retired) Calvin Waller on the subject of *Ethical Leadership.* From these sources, the author compiled a list of questions with which to assess the leadership behaviors. They follow.

Did the leader have all the facts necessary to make an informed decision? For example, did they know and understand the applicable guiding regulations and directives?

Were the leader's actions and words congruent? Did he talk the talk and walk the walk?

Did the leader act in an ethical manner? Would his actions pass the "newspaper test?" 5

Did the leader consider the implications of his actions on subordinates?

Did the leader's actions promote a sound command climate? Did he permit and encourage the free flow of information? Did he require that deviations from standards be reported?

Did the leader enforce established standards? Was the leader able to effectively discipline? Was he fair and decisive?

Senior leadership actions (or lack thereof) will be addressed using a chronological approach and the *Leader--Follower--Situation* framework outlined by Hughes, Ginnett, and Curphy in "Leadership: Enhancing the Lessons of Experience", a textbook used at the Untied States Air Force Academy.

Key Concepts: Airmanship, Rogue Aviators, Leadership, and the Culture of Compliance

At a gut level, most aviators can determine reasonable from unreasonable courses of action, regardless of the nature of the mission. This quality is referred to as ***judgment*** *or* ***airmanship***. From the beginning of an aviator's training, he or she is taught that *"flexibility is the key to airpower"* and is given considerable latitude in employing methods for accomplishing mission objectives. This is one of the major strengths of airpower and should not be changed. But there are also those aviators, usually of high experience, skill, and confidence, who see this built in flexibility as a chaotic environment which may be manipulated for their own ends--often with tragic results. These ***rogue aviators*** are usually popular and respected, possess considerable social skills, and have learned what rules they can break, when, and with whom. They are usually perceived much differently by superiors than by peers or subordinates. This level of sophistication makes the direct oversight role of the supervisor more difficult, and the role of effective command climate more important. What the leader may not recognize *as an individual,* must be identified for him *by the organization.* Further, upon this recognition, the leader **must act**. Failure to act after the organization has fulfilled it's role in identifying a problem, leads to a deterioration of ***faith in the system*** by subordinates, who now feel that their input is of little value. A ***culture of compliance*** must be inculcated and constantly nurtured to prevent the downward spiral into disaster, such as occurred at Fairchild Air Force Base in June of 1994.

The culture of compliance was certainly not in place at Fairchild AFB in the three years preceding the crash of Czar 52. In this case study, the signs of trouble were present early and often. A pattern of negative activity could be found in complaints from other crewmembers, maintenance problems from over-stressing or exceeding aircraft limitations, and stories of the Lt Col Holland's grand accomplishments and plans that circulated throughout the crew force. After reviewing the history contained in the testimonies, one suspects that an energetic historian could find earlier signs of Lt Col Bud Holland's departure from the aviators' "straight and narrow" path of regulatory compliance, but for our purposes we will limit the analysis to the period between 1991 and June of 1994.

By the summer of 1994, the entire Fairchild culture was caught up in the activities of a single B-52 pilot. Red flags of warning were abundant-- and yet those who could act did not do so, in spite of recommendations to ground Bud Holland. As one B-52 crewmember said about the accident, "You could see it, hear it, feel it, and smell it coming. We were all just trying to be somewhere else when it happened." [6]

Section Two: The Players

There were many individuals involved with this story. This section introduces the reader to Lt Col Holland and the command staff at Fairchild AFB during the period of this analysis. The remainder of the personnel will be discussed as they fit into the narrative.

Lt Col Bud Holland

Lt Col Arthur "Bud" Holland was the Chief of the 92d Bombardment Wing Standardization and Evaluation Section at Fairchild Air Force Base. This position made him responsible for the knowledge and enforcement of academic and in-flight standards for the wing's flying operations. By nearly any measuring stick, Bud Holland was a gifted stick and rudder pilot. With over 5,200 hours of flying time and a perfect 31-0 record on checkrides, Lt Col Holland had flown the B-52G and H Models since the beginning of his flying career in March of 1971.[7] He was regarded by many as an outstanding pilot, perhaps the best in the entire B-52 fleet. He was an experienced instructor pilot and had served with the Strategic Air Command's lst Combat Evaluation Group (CEVG), considered by many aviators to be the

"top of the pyramid." But between 1991 and June of 1994, a pattern of poor airmanship began to surface. Perhaps his reputation as a gifted pilot influenced the command staff, who allowed this pattern of behavior to continue. The following were typical comments from Lt Col Holland's superiors:

"Bud is as good as a B-52 aviator as I have seen." [8]

"Bud was ... very at ease in the airplane ... a situational awareness type of guy. - - among the most knowledgeable guys I've flown with in the B-52."[9]

"Bud was probably the best B-52 pilot that I know in the wing and probably one of the best, if not the best within the command. He also has a lot of experience in the CEVG which was the Command Stan Eval ... *and he was very well aware of the regulations and the capabilities of the airplane* (emphasis added)." [10]

A far different perspective on Lt Col Holland's flying is seen in statements by more junior crewmembers, who were required to fly with him on a regular basis.

"There was already some talk of maybe trying some other ridiculous maneuvers. - - his lifetime goal was to roll the B-52." [11]

"I was thinking that he was going to try something again, ridiculous maybe, at this airshow and possibly kill thousands of people" [12]

"I'm not going to fly with him, I think he's dangerous. He's going to kill somebody some day and it's not going to be me." [13]

"(Lt) Col Holland made a joke out of it when I said I would not fly with him. He came to me repeatedly after that and said 'Hey, we're going flying Mikie, you want to come with us.' And every time I would just smile and say, 'No. I'm not going to fly with you." [14]

"Lt Col Holland broke the regulations or exceeded the limits ... virtually every time he flew." [15]

The reasons for these conflicting views may never be entirely known, but hint at a sophisticated approach to breaking the rules that became a pattern in Lt Col Holland's flying activities. Additionally, some light can be shed on the issue by looking at the rapid and frequent turnover of the 92d Bomb Wing senior staff.

The Shifting Command Structure

The 92d Bomb Wing experienced numerous changes to its wing and squadron leadership during the period from 1991 to 1994. The changes included four wing commanders, three vice wing commanders, three deputy commanders for operations/operations group commanders, three assistant deputy commanders for operations, and five squadron commanders at the 325th BMS. Figures 1 and 2 show a leadership timeline at the 92d Bomb Wing from mid 1990 through mid 1994. Above the timeline are listed the eight significant events that will be analyzed. As the discussion proceeds, the interaction between incoming and outgoing members of the staff will be addressed.

Section Three: The Events

Each of the events leading up to the crash of Czar 52 on 24 June 1994 provides insights on leadership performance. We will analyze each event by providing a synopsis of what occurred, as determined from eyewitness testimony. Secondly, we will look at the action of the followers, which were typically (but not always) B-52 air crewmembers. Finally, we will conclude the analysis of the event with a look at the leader's actions. This framework, or model for analysis is suggested by leading researchers for use in the case study approach. [16] It is important to understand that a historical case study cannot provide definitive guidance for other situations. All situations are unique and must be defined in terms of their own circumstances. It is hoped, however, that this discussion will provide some general lessons that may carry over into other environments.

Situation One: Fairchild AFB Airshow 19 May 1991

Lt Col Holland was the pilot and aircraft commander for the B-52 exhibition in the 1991 Fairchild AFB air show. During this exhibition, Lt Col Holland violated several regulations and tech order (T.O. 1B-52G-1-11, *a.k.a. Dash 11)* limits of the B-52, by (1) exceeding bank and pitch limits, and (2) flying directly over the airshow crowd in violation of Federal Aviation Regulation (FAR) Part 91. In addition, a review of a videotape of the maneuvers leaves one with the distinct impression that the aircraft may have violated FAR altitude restrictions as well.

The Followers

Many of the crewmembers who were at Fairchild for the 1991 airshow were unavailable for interview, but it appears as if there was no large public or private outcry as a result of the 1991 B-52 exhibition. However, some aircrew members had already began to lose faith in the system. One B-52 pilot, when asked why more crewmembers didn't speak up about the violations, said, "The entire wing staff sat by and watched him do it (violate regulations) in the '91 airshow. What was the sense in saying anything? *They had already given him a license to steal* (emphasis added)." [17]

The Leaders

There is no evidence to indicate that commanders at any level took any action as a result of Lt Col Holland's flight activities. There is no indication that either the wing commander (Col Weinman) or the deputy commander for operations (Col Julich) was aware that the profile flown was in violation of existing MAJCOM regulations or FARS. However, there can be little doubt that they were both aware that the profile violated the Dash 11 T. 0. Both men were experienced pilots and were undoubtedly aware of the bank and pitch limitations of the B-52 in the traffic pattern environment, which were grossly exceeded as they personally observed the flyover.

Analysis

The Fairchild leadership failed in two major areas. The first was allowing a command climate in which such a blatant violation of air discipline could be planned, briefed, and carried out without interference. The fact that Lt Col Holland planned and briefed a profile that did not meet established regulatory and Tech Order guidelines suggests a complacent command climate. J. K. Van Fleet, in "The 22 Biggest Mistakes Managers Make," would see this as "a failure to make sure that the job is understood, supervised, and accomplished." [18] One could argue that this level of oversight was unnecessary, since Lt

Col Holland, as the Chief of wing Stan-Eval, was a senior officer with a great deal of experience. If this argument is accepted, then the leadership failed to act decisively after the violations occurred. William Roberts, in "Leadership Secrets of Attila the Hun" would see this failure to act as a lost teaching opportunity. "Chieftains must teach their Huns what is expected of them. Otherwise, Huns will probably do something unexpected of them." [19] Simply stated, the wing commander and DO did not know certain things they should have known (like command regulations on airshows) and did not enforce standards on violations of regulations that they clearly understood. This would not be the only lost teaching opportunity.

Interestingly, the wing commander had a reputation for demanding strict adherence to air discipline. While acting as the commander of a provisional bomb wing at Andersen AFB, Guam, in GIANT WARRIOR 1990, Colonel Weinman had been very proactive to prevent low altitude violations during airfield attack portions of the exercise. After two days of observing aggressive simulated airfield attacks at Andersen, he remarked, "If we keep trying to outdo each other every day, there is only one way this is going to end--with somebody getting killed. The next guy that busts an altitude will talk to me personally and explain why I shouldn't ground him and send him home." [20] The author could find no explanation for the apparent disconnect between what Col Weinman demanded in the provisional wing and what he allowed to occur at his own airshow.

Situation Two: 325th BMS Change of Command "Fly Over" 12 July 1991

Lt Col Holland was the aircraft commander and pilot for a "fly over" for a 325th BMS Change of Command ceremony. During the "practice" and actual fly over, Lt Col Holland accomplished passes that were estimated to be "as low as 100-200 feet." [21] Additionally, Lt Col Holland flew steep bank turns (greater than 45 degrees) and extremely high pitch angles, in violation of the Dash 11 Tech Order, as well as a "wingover"-- a maneuver where the pilot rolls the aircraft onto its side and allows the nose of the aircraft to fall "through the horizon" to regain airspeed. The Dash 11 recommends against wingover type maneuvers because the sideslip may cause damage to the aircraft.

The Followers

Because most of the 325th BMS personnel were standing at attention in ranks for the Change of Command ceremony, they did not personally see the violations as they occurred. Most had to rely on descriptions from family and friends. The followers were acutely aware, however, that the senior staff had a ringside seat, and therefore may not have felt the need to report or complain about a situation that their leaders had witnessed directly.

The Leaders

This time the leadership was forced to take action. The ADO (Col Capotosti) went to the DO (Col Julich) and remarked "We can't have that, we can't tolerate things like that, we need to take action for two reasons--it's unsafe and we have a perception problem with the young aircrews." [22] Evidence indicates that Lt Col Holland may have been debriefed and possibly verbally reprimanded by either (or both) the DO and wing commander. However, Lt Col Harper, the outgoing Bomb Squadron commander stated, "No overt punishment that I know of, ever occurred from that (the Change of Command flyover)." [23]

Analysis

Failures in oversight, an ineffective command climate, and a lack of continuity between words and disciplinary actions earmarked the leadership response to this situation. As in the previous situation, the flyover plan was developed, briefed, and executed without intervention. The flyover for a change of command required approval by the USAF Vice Chief of Staff. [24] No such approval was requested or granted. Although the senior staff was spurred to action by the magnitude of the violations, the response appeared to be little more than a slap on the wrist, a point certainly not missed by other flyers in the wing.

Situation Three: Fairchild Air Show
17 May 1992

Lt Col Holland flew the B-52 exhibition at the Fairchild Air Show. The profile flown included several low altitude steep turns in excess of 45 degrees of bank, and a high speed pass down the runway. At the completion of the high speed pass, Lt Col Holland accomplished a high pitch angle climb, estimated at over 60 degrees nose high. At the top of the climb, the B-52 leveled off using a wingover maneuver. [25]

The Followers

Once again, perhaps because the senior staff were eyewitnesses to the violations, the junior crewmembers kept their opinions on the flyby to themselves. A B-52 pilot remarked, "I was amazed that they (the senior staff) let him keep doing that. Getting away with it once you could understand, you know -- forgiveness is easier to get than permission. But this was the third time in less than a year." [26]

The Leaders

The wing commander was Col Ruotsala and the Deputy Commander for Operations (DO) was Col Julich. The DO was TDY during the airshow planning sessions from January to April 1992, and was to leave for another assignment within a month after the airshow. [27] The Assistant Deputy Commander for Operations (ADO), Col Capotosti, did not take part in any of the airshow planning due to a family emergency. [28] As a result, the normal command structure was not in place for the planning phase of the airshow. The ADO, Col Capotosti, was to move up to DO a week after the air show. He was upset by the lack of Lt Col Holland's air discipline and told his wife "This will never happen again. In seven days, I'll be the DO. Lt Col Holland will never fly another airshow as long as I am the DO." [29] After he took over as DO, Col Capotosti "took Holland in and told him to his face, behind closed doors, 'If you go out and do a violation and I become aware of it, I will ground you permanently." [30] Although Col Capotosti began to keep a folder on flyover and airshow regulations, there was no documentation of the reprimand or counseling given to Lt Col Holland in any form.

Analysis

A lack of attention to detail, failure to adequately discipline, and a failure to document counseling, were the primary leadership failures at this juncture. Once again, the required waivers were not obtained for the B-52 demonstration. The wing commander stated "I guess I assumed that it had been approved because there are a lot of other flyovers, or flying events ... and it was all kind of bunched up into one approval for the event." [31] This was an incorrect assumption. The outgoing DO took no disciplinary action, perhaps feeling that the new DO would handle the situation. The incoming DO's statement that "this will never happen again" was soon to be qualified with "as long as I'm the DO." Perhaps more significant was the fact that the counseling sessions which apparently occurred after the **last incident** (Change of Command flyover, 12 July 91), were apparently not passed on to the new DO. If there had been any implied or stated threats to Lt Col Holland after the last event, such as "If you do this again,

you are grounded." they were not passed along. This left the new DO at "step one" in the disciplinary process. By this time, the credibility of the senior staff had been severely damaged, and the DO's verbal reprimand most likely sounded hollow to Lt Col Holland, who had been verbally reprimanded by the wing commander for similar violations the previous July. Apparently, the senior staff at the 92d Bomb Wing was unwilling to take preventative disciplinary action, even after three public displays of intentional and blatant deviations from regulations and Technical Orders. Further deterioration of airmanship should not have come as a surprise.

Situation Four: Global Power Mission
14-15 April 1993

Lt Col Holland was the mission commander of a two-ship GLOBAL POWER mission to the bombing range in the Medina de Farallons, a small island chain off the coast of Guam in the Pacific Ocean. While in command of this mission, Lt Col Holland flew a close visual formation with another B-52 in order to take close up pictures. [32] This type of maneuver was prohibited by Air Combat Command (ACC) regulations. [33] Later in the mission, Lt Col Holland permitted a member of his crew to leave the main crew compartment and work his way back to the bomb bay to take a video of live munitions being released from the aircraft. This was also in violation of current regulations. [34]

The Followers

The members of the crews on this GLOBAL POWER mission participated in the unauthorized activities that took place. When questioned as to why they did this, several crewmembers testified that Lt Col Holland told them that the wing commander, Brigadier General Richards, had instructed him to do "whatever you need to do, to get good pictures." [35] The pictures and video which resulted were clear and unequivocal evidence that regulations had been broken.

The Leaders

After the mission, the 325th BMS commander, Lt Col Bullock, became aware of the video. One crewmember testified that the squadron commander attempted to coerce him into taking a job as the wing scheduler by using the videotape as "blackmail." [36] The crewmember was so upset with this development that he went to the base Judge Advocate General (JAG) to file a complaint, but was told "he could not win." [37] Lt Col Bullock denies these events took place and states that "no one told him specifically" that illegal events had taken place on the flight. [38] The same crewmember later showed the video to the Deputy Operations Group Commander (ADO), Lt Col Harper, who advised him, "I would not show any of this" relating to certain sequences of the video tape which he (Lt Col Harper) felt were in violation of regulations. [39] When the DO was made aware of the presence of the potentially incriminating video he allegedly responded "Okay, I don't want to know anything about that video -- I don't care." [40] The entire episode began with Lt Col Holland's impression that he was given "some orders (presumably from the wing commander) to basically free-style to get good photographs and video ... to make the presentation (of the wing's accomplishments) more spectacular." [41]

Analysis

For the first time, the wing leadership was confronted with "hard copy" evidence of wrong doing on the part of Lt Col Holland. Yet there was apparently no attempt at any level to interview the crewmembers or to reprimand the guilty parties. If the story of blackmail is true, the actions of the squadron commander were dearly unethical and possibly illegal. If they were not true, he still did not enforce existing standards and regulations. The ADO, by his own admission, was aware that illegal activities

had taken place during the flight. He claims to have advised the DO of the problem, which the DO denies. In either case, no disciplinary action was taken as a result of this episode. If the DO actually stated "I don't want to know anything about that video--I don't care" he was clearly complacent and failed in his leadership role by not enforcing standards, as well as inhibiting communications. The wing commander may not have been involved at all in this case, as he denies that he ever told Lt Col Holland to *"do what it takes to get good pictures."* Once again there was no disciplinary action taken or any documentation of counseling.

Perhaps the most disturbing part of this situation is that it shows at least three examples of military officers *telling lies*, an unpardonable breech of integrity. Either the blackmail incident occurred or it did not, either the ADO informed the DO of the problem or he did not, and either the wing commander told Lt Col Holland to "do what it takes" or he did not. It is unlikely that the individuals involved would have forgotten or misinterpreted these events, making it highly likely that several officers lied while testifying to the investigating authority. Integrity--the cornerstone of officership, was clearly lacking at, or within, all three levels of command.

Situation Five: Fairchild Air Show
8 August 1993

Lt Col Holland flew the B-52 exhibition for the 1993 Fairchild air show. The profile included steep turns of greater than 45 degrees of bank, low altitude passes, and a high pitch maneuver which one crewmember estimate to be 80 degrees nose high--ten degrees shy of completely vertical. Each of these three maneuvers exceeded technical order guidance. As was the case in previous air shows, Air Combat Command approval was required, but was neither requested or granted.

The Followers

By now, the crewmembers of the 325th BMS had grown accustomed to Lt Col Holland's air show routine. But a more insidious effect of his ability to consistently break the rules with apparent impunity, was manifested in younger, less skilled crewmembers. In one example, Captain Nolan Elliot, a B-52 Aircraft Commander who had seen several of Lt Col Holland's performances attempted to copy the "pitch-up" maneuver at an airshow in Camloops, Canada--with near disastrous results. [42] The navigator on this flight said "we got down to *seventy* knots and ... felt buffeting" during the recovery from the pitch up. [43] At seventy knots, the B-52 is in a aerodynamically stalled condition and is no longer flying. Only good fortune or divine intervention, prevented a catastrophic occurrence in front of the Canadian audience. A second example occurred at Roswell, New Mexico, when a new Aircraft Commander was administratively grounded for accomplishing a maneuver he had seen Bud Holland do at an air show. "It was a flaps down, turning maneuver in excess of 60 degrees of bank, close to the ground." His former instructor said of the event "I was appalled to hear that somebody I otherwise respected would attempt that. The site commander was also appalled, and sat the man down and administered corrective training." [44] The bad example set by Col Holland had begun to be emulated by junior and impressionable officers, and had resulted in one near disaster and an administrative action against a junior officer. This was precisely what Col Capotosti had feared when he warned the DO about Holland's influence on younger crewmembers in July of 1991.

The Leaders

There was no disciplinary action taken at any level of command as a result of the 1993 airshow.

Analysis

The response to this event from the wing commander, Brigadier General Richards, sheds some light on the nature of the overall leadership problem at Fairchild AFB. In testimony after the crash in June of 94, Richards said of Lt Col Holland, "he never acted ... anything other than totally professional ... *nothing I saw or knew about when I was at Fairchild led me to any other belief* (emphasis added) about Bud Holland." [45] This testimony was from a Wing Commander who personally witnessed Lt Col Holland's flagrant and willful tech order and regulatory violations at his own 1993 air show. Regarding the '93 air show, BG Richards went on to state *"I made it absolutely clear that everything that was going to be done in this demonstration was going to have to be on the up and up and in accordance with tech order and in accordance with the regulations ... and I was sure that it was* (emphasis added)." [46] It is interesting to note, that the site commander at Roswell, New Mexico immediately recognized a high bank maneuver by a B-52 as a violation of tech order guidance, and took administrative action against the offender. What was going on at Fairchild? Did the Wing Commander not know or understand the tech orders or regulations? Was he misinformed? BG Richards states he looked to the DO, Col Pellerin for guidance. [47] Col Pellerin states he looked to his Chief of Stan-Eval, Lt Col Holland for guidance -- and so the demonstration proceeded under the guidance of an aviator who already had been verbally reprimanded (perhaps twice) for willful violations and poor airmanship. [48] A B-52 pilot interviewed about this state of affairs, said "it was worse than the blind leading the blind. It was more like the spider and the fly" referring to the abilities of Lt Col Holland to bend the leadership to his will. [49] Although there was a new DO in place, Col Pellerin did not take any more forceful action than did any of his predecessors. In fact, there was no verbal reprimand or counseling given to Lt Col Holland, as there had been in the past airshows. He may have seen this as another signal of the senior leadership's acquiescence to his brand of airmanship.

Situation Six: Yakima Bombing Range
10 March 1994

Lt Col Holland was the aircraft commander on a single ship mission to the Yakima Bombing Range to drop practice munitions and provide an authorized photographer an opportunity to shoot pictures of the B-52 from the ground as it conducted its bomb runs. Lt Col Holland flew the aircraft *well below* the established 500 foot minimum altitude for the low level training route. In fact, one crossover was photographed at less than *30 feet*, and another crewmember estimated that the final ridgeline crossover was "somewhere in the neighborhood of about *three* feet" (emphasis added) above the ground, and that the aircraft would have impacted the ridge if he had not intervened and pulled back on the yoke to increase the aircraft's altitude. The photographers stopped filming because "they thought we were going to impact . . . and they were ducking out of the way." [50] Lt Col Holland also joined an unbriefed formation of A-10 fighter aircraft to accomplish a flyby over the photographer. This mission violated ACC Regulations regarding minimum altitudes, FAR Part 91 and Air Force Regulation (AFR) 60-16, regarding overflight of people on the ground. There were several occasions during the flight where other crewmembers verbally voiced their opposition to the actions being taken by Lt Col Holland. Following the flight, these same crewmembers went up the squadron chain of command with their story and stated they would not fly with Lt Col Holland again.

The Followers

During the flight, crewmembers strongly verbalized their concerns about the violations of air discipline and regulations. At one point, Lt Col Holland reportedly called the radar navigator "a pussy" when he would not violate regulations and open the bomb doors for a photograph with live weapons on board. On another occasion, following a low crossover, the navigator told Lt Col Holland that the altitudes he was flying was "senseless." [51] But the real hero on this flight was Capt Eric Jones, a B-52 instructor pilot who found himself in the copilot seat with Lt Col Holland during the low level portion of the flight. On

this day, it would take all of his considerable skills, wits, and guile, to bring the aircraft safely back to Fairchild. After realizing that merely telling Lt Col Holland that he was violating regulations and that he (Capt Jones) was uncomfortable with that, was not going to work, Capt Jones feigned illness to get a momentary climb to a higher altitude. Capt Jones also said he needed training and flew a few more passes. But in the end it was once again Lt Col Holland at the controls. The following is Capt Jones recollection of the events that took place then:

> We came around and (Lt) Col Holland took us down to 50 feet. I told him that this was well below the clearance plane and that we needed to climb. He ignored me. I told him (again) as we approached the ridge line. I told him in three quick bursts ***'climb-climb-climb.'*** . . I didn't see any clearance that we were going to clear the top of that mountain ... It appeared to me that he had target fixation. I said ***'climb-climb-climb.'*** again, he did not do it. I grabbed ahold of the yoke and I pulled it back pretty abruptly ... I'd estimate we had a cross over around 15 feet . . . The radar navigator and the navigator were verbally yelling or screaming, reprimanding (Lt) Col Holland and saying that there was no need to fly that low ... his reaction to that input was he was laughing--I mean a good belly laugh. [52]

Following the low level portion of the mission at the Yakima Range, the crew was scheduled to fly another low level at a different route. Capt Jones convinced Lt Col Holland that the other copilot on the flight needed some training. When Lt Hollis climbed in the seat with Capt Jones (replacing Lt Col Holland at the other set of controls) Capt Jones "told Lt Hollis that he was not to get out of the seat again, (even if) Col Holland ordered him to." [53]

Upon returning from the mission, the crewmembers discussed the events among themselves and came to the conclusion that they would not fly with Lt Col Holland again. Capt Jones reports, "I vowed to them that never again would they or myself be subjected to fly with him. That if it required it, I would be willing to fall on my sword to ensure that didn't happen." The next day, Captain Jones reported the events to Major Don Thompson, the squadron operations officer stating "I did not ever want to fly with Lt Col Holland again, even if it meant that I couldn't fly anymore as an Air Force pilot." [54] Major Thompson told Captain Jones that he didn't think it would come to that, because he "was joining a group of pilots in the squadron who had also made the same statement." [55]

The Leaders

The staff at the squadron level began to take action when Captain Jones reported the events to Major Thompson, the squadron Ops officer. Major Thompson had also already seen a video tape taken from the ground during the photography session the previous day and was aware of the severity and degree of the infractions. Although he was admittedly a good friend of Bud Holland, Major Don Thompson had seen enough. He immediately went to the Squadron Commander, Lt Col Mark McGeehan. Major Thompson recalls, "I had an intense gut feeling that things were getting desperate ... I said 'I feel like I'm stabbing a friend in the back. I like (Lt) Col Holland but we need to remove him from flying. That Yakima flight needs to be his fini-flight.' I guess I was just trying to protect Bud Holland from Bud Holland." [56] The Squadron Commander concurred with his Ops officer, but it was agreed that in order to restrict the wing Chief of Stan-Eval from flying, the order would have to come from the DO. Lt Col Mark McGeehan went to see Col Pellerin. At the meeting, Lt Col McGeehan laid the facts on the table and made his recommendation to ground Bud Holland. The DO thanked him and said he would get back to him with a decision after he had heard the other side of the story. Colonel Pellerin consulted with Lt Col Holland and was told that he (Holland) was just trying to demonstrate aircraft capabilities to the more junior crewmembers. Lt Col Holland was verbally reprimanded by Col Pellerin (undocumented) and promised not to break any more regulations in the future. The DO then called a meeting with Lt Col

Holland and Lt Col McGeehan to announce his decision. He informed them both that he had reprimanded Lt Col Holland but that he had decided against any restriction on his flying. At that point, Lt Col McGeehan made a decision to restrict his crews from flying with Lt Col Holland unless he was in the aircraft. According to his wife "Mark said afterwards that he knew that he was not going to let (Lt) Col Holland fly with anybody else unless he was in the airplane ... that he was going to be flying whenever Bud flew." [57] He was true to his word.

Analysis

The squadron leadership at the 325th BMS performed admirably. After acquiring the facts and evidence, the squadron senior staff reached a logical conclusion and made an ethical and appropriate decision. They attempted to use the chain of command to enforce established standards and upchannelled the information to the appropriate level. After the decision of the DO was rendered, they saluted smartly and went about taking actions that *were* within their purview, in an attempt to do what they could to keep everyone safe.

There were two apparent failures at the DO level. First, Col Pellerin did not obtain all of the available information. He did not view the videotape of the event, and he did not contact previous senior wing leaders to ascertain if Lt Col Holland had a history of airmanship problems. This leadership error was not unique in the history of the 92d Bomb Wing. When confronted with clear evidence of willful violations of regulations, Colonel Pellerin did not take proactive action to prevent a reoccurrence. *Once again, the unrecorded verbal reprimand was the extent of the disciplinary action.* By failing to take further action, the DO had set the stage for a bizarre and dangerous situation. Two men (Lt Cols McGeehan and Holland) who were professionally at odds, were to be paired in the cockpit for the next several months. Lt Col McGeehan had confided in his wife that he did not trust Bud Holland to fly with his aircrews. Captain Eric Jones related the following encounter with Lt Col Holland (after the DO's decision):

> I was sitting there and he came over and said "That little f--- er," referring to Lt Col McGeehan, "tried to get me grounded. But I solved that, the three of us." And Lt Col Holland told me, speaking directed at Lt Col McGeehan, that he didn't respect him as a man, as a commander, or as a pilot. Apparently Lt Col McGeehan had said something about him being dangerous and Lt Col Holland indicated that he told him that he was just a "weak dick." [58]

The DO had not adequately considered the implications of his actions when he allowed Bud Holland to continue to fly. Within his Operations Group there was, in essence, a small mutiny going on. Many of the crewmembers were no longer willing to fly with his Chief of Standards and Evaluation, *even under orders.* He had alienated his Bomb squadron commander, who was now having to spend time tracking the flying schedule of Bud Holland, to ensure that his crewmembers were not put in the unenviable position of choosing between risking their careers or risking their lives. The DO's last error was that he failed to pass either the information or his decision up to the wing commander, Colonel Brooks, who remained unaware of the entire situation.

The Command Climate at Fairchild AFB in Early 1994

The Yakima mission brought to a head many emotions that had been lying beneath the surface at Fairchild. In addition to the problems in the Operations Group, the antics of Bud Holland were being discussed by the officer's wives, civilians, and even on the high school playground.

The rift that existed between Lt Col McGeehan and Lt Col Holland extended beyond the men themselves. A B-52 aircraft commander stated "Everybody was lining up on one side or the other, Bud had his groupies, and then there were the rest of us." [59] The effects and strain was also felt by Lt Col McGeehan's wife Jodi, who related a conversation she had with Bud Holland's wife, Sarah Ann. "I was at Donna Pellerin's going away luncheon and I never really had a chance to meet Sarah in the whole year . . . somebody mentioned something about one of the airshows, and Sarah Ann just turned to me and she said 'You know, there is not anybody that could do anything to stop my husband from flying the way he wants to fly." [60] The children were no more exempt from the controversy than were the wives. Patrick McGeehan, Mark and Jodi's oldest son came home from school one day extremely angry at Victoria Harper, the daughter of the Lt Col Steve Harper, the Deputy Operations Group Commander. When his mother asked him why he was so upset he replied, "well all year long she just kept telling me that the best pilot in the squadron was Colonel Bud Holland ... it annoyed me, but the thing that really annoys me the most now is that she said that if anybody is going to roll the B-52, Bud Holland is going to be the one to do it, and I can just see him doing it some day." [61]

There is also some evidence to suggest that the local civilian community was aware of the controversy swirling around Lt Col Holland's flying practices. One civilian complained to the local TV news that a B-52 was in 60 to 70 degrees of bank over the local supermarket in Airway Heights. [62]

But it was the crew force morale that was most effected. Captain Shawn Fleming, an B-52 instructor pilot and a weapons school graduate, was an opinion leader within the squadron, and summed up the feelings many 325th BMS aviators had about Lt Col Holland's airmanship, and the wing leadership's actions related to it.

> Everybody had a Col Holland scare story. Col Holland was kind of like a crazy aunt ... the parents say "Ignore her" . . . and the hypocrisy was amazing. For him to be in the position of the Chief of Standardization ... is unconscionable. When Col Holland did something ... he's patted on the back by the leadership, "Good Show." What's the crew force supposed to learn from that? You got the "He's about to retire" (and) "That's Bud Holland, he has more hours in the B-52 than you do sleeping." Yeah, he might have that many hours, but he became complacent, reckless, and willfully violated regulations. [63]

By June 1994, the command climate at Fairchild Air Force Base was one of distrust and hostility. "Everybody was just trying to get out of here." [64] In spite of these facts, Lt Col Holland was selected by Col Pellerin to perform the 1994 airshow. "It was a non-issue,"' Pellerin said. "'Bud was Mr. Airshow."

Situation Seven: Air Show Practice
17 June 1994

Lt Col Holland and the accident crew flew the first of two scheduled practice sessions for the 1994 airshow. The profile was exactly the same as the accident mission except that two profiles were flown. Once again they included large bank angles and high pitch climbs in violation of ACC regulations and technical order guidance. The wing commander, Col Brooks, had directed that the bank angles be limited to 45 degrees and the pitch to 25 degrees. These were still in excess of regulations and technical order guidance. Both profiles flown during this practice exceeded the wing commander's stated guidance. However, at the end of the practice session, Col Pellerin, the DO, told the wing commander that "the profile looks good to him; looks very safe, well within parameters." [65]

The Followers

Because the 325th BMS was scheduled to close, most of the bomb squadron crewmembers had already been transferred to new assignments. But those that remained were not comfortable with the situation. In fact, one of the squadron navigators refused to fly the airshow if Lt Col Holland was going to be flying. This required the ranking navigator in the 325th BMS, Lt Col Huston, to be the navigator for the airshow and practice missions. [66] Major Thompson, the squadron Operations Officer was also uneasy. "I had this fear that he was again going to get into the airshow . . . that he was going to try something again, ridiculous maybe and kill thousands of people." [67]

It wasn't just the flyers that were getting nervous. Lt Col (Dr) Robert Grant, the 92d Air Refueling Squadron Flight Surgeon, was told by a crewmember during a routine appointment, that he refused to fly with Lt Col Holland. This, coupled with a concern that Lt Col Holland was scheduled to fly in the 1994 airshow, led Dr. Grant to take his concerns to both the 92d Bomb Wing Chief of Safety, Lt Col Mike McCullough, and to Dr. Issak, the Chief of Aeromedical Services at Fairchild. The Chief of Safety told Dr. Grant that "Lt Col Holland was a good pilot and that the maneuvers had been done before." [68] Dr. Issak did not pursue the issue after he learned that Dr. Grant had spoken to the wing safety officer. [69]

Major Theresa Cochran, the nurse manager in emergency services, attended an airshow planning session in which Lt Col Holland briefed that he planned to fly 65 degree bank turns. The wing commander quickly told him that he would be limited to 45 degrees maximum. Major Cochran recalls Lt Col Holland's response in a prophetic discussion between her and a co-worker who was also in attendance at the planning session.

> Colonel Holland's initial reaction was to brag that he could crank it pretty tight ... he said he could crank it tight and pop up starting at 200 (knots). Bob and I looked at each other, and Bob is going, "He's f---ed.", and I said "I just hope he crashes on Friday, not Sunday, so I will not have so many bodies to pick up." . . those words did return to haunt me. [70]

The Leaders

During the planning session briefing on June 15, Lt Col Holland briefed using overhead slides (see Appendix). As the briefing progressed, Col Brooks, the wing commander, made clear that (1) there would be no formation flight, (2) bank angles would be limited to 45 degrees, and (3) that pitch angles would be limited to 25 degrees. [71] Although the slides and briefing clearly indicated that a part of the demonstration would include a "wingover," there was curiously no discussion on this point. Although Lt Col Holland was clearly not pleased with the wing commander's guidance, there is no doubt that he left the briefing with an understanding of what the commander's guidance was. During the practice mission, the commander's guidance was repeatedly violated, but was not reported as such by Col Pellerin, the DO to the wing commander. The wing commander had only personally witnessed a small portion of the practice, because he was at a rehearsal for a retirement ceremony for the outgoing Base Commander. Lt Col Ballog, who was serving as the Commander of Troops on the parade field at this rehearsal, recalls Col Brooks making a negative comment about the portion of the airshow practice that he was able to see. "The comment was basically, that this was not supposed to be happening ... not a part of the agenda . . that he (Lt Col Holland) was too low and banking over too hard ... which were contrary to guidance that had been put out." [72] In spite of this personal observation, no action was taken following the report of "well within parameters" by the DO upon landing from the practice session.

Analysis

Once again, there was incongruity between senior leadership words and actions. After stating that certain safety criteria (which still exceeded regulatory and T.O. guidance) regarding bank and pitch

angles would be followed, the senior leadership personally witnessed the violations. The DO witnessed them from the aircraft and the wing commander witnessed them from the ground. Both undoubtedly knew that the deviations were intentional. Lt Col Holland's unquestioned flying skills ruled out the possibility that these overbanks and excess pitch angles were simply slip ups or errors. Yet no action was taken.

It appears that at this point, the leadership had given up on enforcing standards with regards to Lt Col Holland. Further, they appeared to be unable to read an atmosphere of impending disaster that permeated nearly every aspect of the 92d Bomb Wing.

On Monday, the 20th of June, disaster did strike Fairchild AFB, but it was not the one that is the focus of this analysis. A lone gunman entered the base hospital and killed several Air Force members before being shot and killed by a security police officer responding to the scene. Understandably, the airshow and all preparations for it were immediately put on hold. After some discussion, it was determined that going ahead with the airshow would aid in the healing process of the personnel still at the base, and so another practice session was scheduled for the morning of 24 June.

On that morning, Secretary of the Air Force Sheila Widnall and United States Congressman Tom Foley visited the base, so the takeoff for the practice session was delayed until the afternoon. At 1335 Pacific Daylight Time (PDT), Czar 52 taxied to runway 23 for departure. At 1416 PDT, the aircraft impacted the ground killing all aboard.

Section Four: Conclusions and Implications

Leadership exists in direct proportion to the degree to which subordinates are willing to follow. Leadership is a social phenomenon When followers cease to follow, leaders cease to lead. This is true even if the "leaders" hold high military ranks and fill positions of great power and responsibility. To a large degree, this was what had occurred within the 92d Bomb Wing at Fairchild AFB in the early 1990s. Describing **what** occurred is interesting and insightful, but determining **why** it occurred is absolutely essential if we are to avoid similar catastrophes in the future. Using the questions posed in Section One of this study, the following conclusions were reached.

Followers stopped following.

Just as "up" has no meaning without the concept of "down," leadership must be defined in terms of followership. On an individual basis, Lt Col Holland refused to follow written regulations and B-52 tech orders, as well as ignoring the verbal orders and guidance given by the Wing Commanders and DOs. Even when verbal reprimands and counseling sessions focused on the specific problem of airmanship, he steadfastly refused to follow their guidance. At one point, only weeks prior to the accident, he clearly stated his feelings on the issue of guidance from senior officers.

> I'm going to fly the airshow and yeah, I may have someone senior in rank flying with me, - - . he may be the boss on the ground, but I'm the boss in the air and I'll do what I want to do.[74]

The aircrews quickly perceived this as an integrity problem within the leadership. The flyers, and eventually other members in the wing, simply lost faith in the leadership's ability to deal with the problem. Capt Brett Dugue summed up the crewmember's frustration this way. "You've got to be kidding me, if they allowed him to fly a 50 foot fly-by at a change of command, do you think me telling anybody about him flying low at IR 300 is going to do any good?" [75] As a result of this loss of faith the aircrews began to employ other survival techniques, such as feigning illness and openly refusing to fly with Lt Col Holland.

The lesson learned and implication for current and future commanders is that trust is built by congruence between word and deed at all levels. Subordinates are quick to pick up on any disconnect. They are closer to the action, have more time on their hands, and love to analyze their leaders. Retired Air Force General Perry Smith writes, "Without trust and mutual respect among leaders and subordinate leaders, a large organization will suffer from a combination of poor performance and low morale." [76] He was right on target in this case.

Standards were not enforced.

A rogue aviator was allowed, for over three years, to operate with a completely different set of rules than those applied to the rest of the wing aviators. The institutional integrity of the 92d Bomb Wing leadership was severely damaged by this unwillingness to act. The entire leadership structure of Fairchild Air Force Base (above the squadron level) appeared to be operating in a state of denial, hoping for the best until the base closed or Lt Col Holland retired. Why? Either the wing leadership did not understand or know that the rules were being violated, or they chose not to apply them uniformly. The first case illustrates possible negligence and incompetence; the second hints at a lack of integrity.

In the words of retired army Lt General Calvin Waller, *"Bad news doesn't improve with age."* [77] Leaders must act upon information or evidence of noncompliance. If they elect not to act, they should communicate their reasons for not doing so. Failure to do either invites second guessing and criticism, often eroding the critical element of trust between the leader and the led. Leaders must also learn to recognize the traits of the rogue aviator, for while Lt Col Holland stood out like a beacon, many others still operate today to a lesser degree.

A key position was filled with the wrong person.

Selecting an aviator who exercised poor airmanship as the Chief of Stan Eval was a poor choice, but leaving him there after multiple flagrant and willful violations of regulations sent an extremely negative message to the rest of the wing flyers. Individuals who hold key positions are looked up to as role models by junior crewmembers. They must be removed if they cannot maintain an acceptable standard of professionalism. Even if Lt Col Holland had not crashed, the damage he had done through his bad example of airmanship is incalculable. Not only did many young officers see his lack of professionalism as a bad example, but they also observed several senior leaders witness his actions and fail to take any corrective action. What this said to them about Air Force leadership in general is uncertain, but in at least one case, it led an otherwise satisfied Air Force pilot to try civilian life. "I wanted no part of an organization that would allow that kind of thing to continue for years on end. We (the crewmembers) pointed it out to them (the leaders) over and over again. It was always the same response -- nothing. I'd had enough." [78]

General Perry Smith states, "Leaders must be willing to remove people for cause . . . the continued presence of ineffective subordinates, drain the organization and its capable leaders of the time, energy, and attention needed to accomplish the mission." [79] He goes on to explain, "If the person is fired for

cause, there should be no question remaining about why the person was fired and that the cause was an important one." [80] The implication for current and future leaders is simply to select key personnel carefully, with an understanding that they are role models and will help shape the personality of the entire organization. If a mistake is made by selecting the wrong person for a key position, remove that person if there is cause so that you don't compound the original error.

The senior leadership positions did not speak with continuity.

That is to say that when an individual Wing Commander or DO issued an ultimatum, like "If you do this again, I will ground you," they did not pass this information along to their replacement. Consequently, new commanders were left having to deal with the problem as if were new. Lt Col Holland undoubtedly viewed this situation like a "get out of jail free" card, a new commander or DO equaled a fresh start. While outgoing leaders didn't fulfill their responsibility to inform new commanders, incoming commanders didn't ask the right questions.

One recommended technique when there is little or no overlap of commanders, is for the outgoing leader to make an audio tape and file for the incoming leader detailing any problem areas or "skeletons in the closet" that would lend continuity to an organization during the crucial transition period. [81] In any case, critical information must be passed along to preserve the "corporate memory" and integrity of a command position.

Leaders did not keep open channels of communication.

In some cases, the problem was blatant and obvious, such as the DO who told a subordinate "I don't want to know about any video. I don't care," after the Global Power mission. In other cases it was more subtle. The fact that the DO did not inform the Wing Commander of the Yakima Bomb Range issue, with the resultant request for Lt Col Holland's grounding, begs the question "Why didn't he tell the boss?" Would the Wing Commander have made the same decision to keep Lt Col Holland flying? Perhaps the DO did not want to "air dirty laundry" outside of the Ops Group, or perhaps the Wing Commander was unapproachable with bad news. These are purely speculative statements, but are mentioned here to get the reader to analyze similar traits in themselves or leaders they have worked for, and to emphasize the importance of communication throughout the chain of command. This is especially important now that there are Brigadier Generals as wing commanders throughout the Air Force. The flag rank adds a new factor to the communication equation and can make it much more difficult for subordinate to feel comfortable bringing the bad news to the boss.

A Final Perspective

The crash of Czar 52, like most accidents, was part of a chain of events. These events were facilitated through the failed policies of several senior leaders at the 92d Bomb Wing. These failures included an inability to recognize and correct the actions of a single rogue aviator, which eventually led to an unhealthy command climate and the disintegration of trust between leaders and subordinates. However, in most aircraft mishaps, the crash is the final domino to drop in the cause and effect chain of events. In this case, however, scores of young and impressionable aviators "grew up" watching a rogue aviator as their role model for over three years. They remain on active flying status in various Air Force wings, passing along what they have learned. Because of this, the final domino in this chain of events may not yet have fallen.

Endnotes

All Endnotes that include Tab numbers, for example "V-21.7," refer to the USAF 110-14 Accident Investigation Board Report of the B-52 Mishap at Fairchild AFB, 24 June 1994.

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1 Telephone interview with Major Kramer (pseudonym), 16 Dec 94. Pseudonym used for prologue continuity. Actual name withheld by request

2 Perry M. Smith, Taking Charge: A Practical Guide for Leaders (Washington, DC: National Defense University Press, 1986) xiii.

3 Michael G. McConnell, Col, USAF, "Executive Summary," AFR **110-14** USAF Accident Investigation Board, Vol 1 ed.: 1.

4 Medical Statement to the Accident Board from 93rd Med Group/SGP, 19 Aug 94

5 As a test of ethical soundness, Lt General (Ret) Waller asked himself the question "If this came out in the newspaper, could I defend my actions as honorable?"

6 Personal Interview, Captain Pilot who preferred to remain anonymous, 525th BMS.

7 Aeronautical Order (PA) Aviation Service, 92d Bombardment Wing, Combat Support Group, IO Mar 89.

8 Col Compotosti, V-3.3.

9 Col Brooks, V-2.8.

10 Col Ruotsala, V-6.3.

11 Major Don Thompson, V-21.4.

12 Major Don Thompson, V-21.7.

13 Captain Brett Dugue', B-52 Aircraft Commander, V-27.10.

14 Captain Mike Meyers, V-32.10.

15 Mr. Al Brown, Former B-52 instructor pilot, V-32.3.

16 Richard L. Hughes, et. al., Leadership: Enhancing the Lessons of Experience (Homewood, IL: Irwin Publishers, 1993) 66-86.

17 Personal Interview, Captain B-52 Pilot who preferred to remain anonymous, 525th BS.

18 J. K. Van Fleet, The 22 Biggest Mistakes Managers Make (West Nyack, N. Y.: Parker, 1973) 9-17.

19 William Roberts, Leadership Secrets of Attila the Hun (New York: Warner Books, 1985) 61-63.

20 The author was present at the post-mission debriefing in which this comment was made.

21 Col Capotosti, V-3.5.

22 Col Copotosti, V-3.6.

23 Lt Col Steve Harper, V-5.6.

24 AFR 110-14 Accident Investigation Board, AA-2.7.

25 AFR 110-14 Accident Investigation Board, Vol 1, Executive Summary, p. 5.

26 Personal Interview, Captain Pilot who preferred to remain anonymous, 525th BMS.

27 Col Julich, V-7.3.

28 Col Capotosti, V-3-9.

29 Col Capotosti, V-3.10.

30 Col Capotosti, V-3.10.

31 Col Ruotsala, V-6.6.

32 Capt Donnelly, V-26.18.

33 Air Combat Command Message, DTG 281155Z Feb. 94.

34 Capt Donnelly, V-26.20.

35 Capt Donnelly, V-26.19.

36 Capt Donnelly, V-26.23. According to Capt Donnelly, Lt Col Bullock stated 'This is the blackmail part." and went on to say that the wing commander knew about the video and wanted to court martial Capt Donnelly, but he (Lt Col Bullock) stepped in to prevent it. However, if Capt Donnelly did not take the job in scheduling, Lt Col Bullock would see to it that the court martial went through. It was later discovered that the wing commander was unaware of the existence of the videotape and had no intention of court martialing Capt Donnelly.

37 Capt Donnelly, V-26.26.

38 Lt Col Bullock, V-1 1.7.

39 Capt Donnelly, V-26.26.

40 Capt Donnelly, V-26.29.

41 Capt Donnelly, V-26.32.

42 Capt Donnelly, V-26.12.

43 Capt Donnelly, V-26.12. This airspeed is approximately 80 knots below minimum inflight airspeed for flaps up maneuvering in the B-52. If the seventy knot figure is accurate, the aircraft had already stopped flying and the resultant "recovery" was merely a fortunate pitch down into the recovery cone. The aircraft could just as easily departed controlled flight.

44 Capt Al Brown, V-32.7.

45 BG Richards, V-1.4.

46 BG Richards, V-1.8.

47 BG Richards, V-1.6.

48 Col Pellerin, V-8.30-31.

49 Personal Interview, Captain B-52 Pilot who preferred to remain anonymous, 325th BMS.

50 Capt Jones, V-28.8.

51 Capt Jones, V-28.9.

52 Capt Jones, V-28.9.

53 Capt Jones, V-28.1 1.

54 Capt Jones, V-28.13.

55 Capt Jones, V-28.13.

56 Maj Thompson, V-21.7.

57 Mrs Jodi McGeehan, V-33.3.

58 Capt Jones, V-28.18.

59 Personal Interview, Captain B-52 Pilot who preferred to remain anonymous, 325th BMS.

60 Mrs. Jodi McGeehan, V-33.4.

61 Mrs. Jodi McGeehan, V-33.8.

62 Capt Fleming, V-39.5.

63 Capt Fleming, V-39.7.

64 Personal Interview, Captain B-52 Pilot who preferred to remain anonymous, 325th BMS.

65 Col Brooks, V-2.23.

66 Maj Thompson, V-21.7.

67 Major Thompson, V-21.7.

68 Dr. Grant V-14.7.

69 Dr. Issak, V-41.

70 Major Cochran, V-1 9.7.

71 Col Brooks, V-2.15-16.

72 Lt Col Ballog, V-9.3.

73 Richard L. Hughes, et. al., Leadership: Enhancing the Lessons of Experience (Homewood IL: Richard D. Irwin, Inc., 1993) 8.

74 Maj Thompson, V-21.1 0.

75 Capt Dugue, V-25.20.

76 Perry Smith, Taking Charge: A Practical Guide for Leaders (Washington, DC: National Defense University Press, 1986) 4.

77 Lt Gen (Retired) Calvin Waller, CGSC lecture slides.

78 Former B-52 instructor pilot, name withheld by request.

79 Perry Smith, Taking Charge: A Practical Guide for Leaders (Washington, DC: National Defense University Press, 1986) 8.

80 Perry Smith, Taking Charge: A Practical Guide f(-)r Leaders (Washington, DC: National Defense University Press, 1986) 50.

81 Perry Smith, Taking Charge: A Practical Guide for Leaders (Washington, DC: National Defense University Press, 1986) 17.

DAVIS-MONTHAN AFB, Adz. (AFNS) - Air Force Col. William E. Pellerin was sentenced to forfeit $1,500 per month for five months and to receive a written reprimand May 22 after being found guilty of two allegations of dereliction of duty associated with his performance of duty as commander of the 92nd Operations Group at Fairchild AFB, Wash., last year.

Pellerin had pleaded guilty to the two offenses in a military judge alone proceeding on May 19. His plea was part of a pretrial agreement in which he offered to plead guilty to the two offenses in exchange for a third offense being dismissed and limitations on the amount of punishment which could be imposed.

By law, the agreed-upon punishment limitations were not disclosed to the judge until after he announced his own adjudicated sentence. However, the pretrial agreement's sentence limitation will not affect the judge's announced sentence, because the judge's sentence did not exceed the agreed limits.

The first dereliction of duty of which Pellerin was found guilty involved failure to obtain required higher headquarters approvals for aerial maneuvers and failing to ensure that maximum bank angles were not exceeded in airshow-related flights. The second dereliction involved failure to make adequate inquiry into a pilot's qualifications to perform flying duties after becoming aware of issues concerning the pilot's airmanship and air discipline.

The pilot and crew died in a B-52 crash in 1994 while practicing for an airshow at Fairchild.

The offense that was dismissed was an allegation that the accused had been derelict in his duties by failing to remove the pilot from flying duties.

About the Author

Major Tony Kern is a U.S. Air Force pilot with operational experience in the Rockwell B-1B supersonic bomber, Boeing KC-135 Tanker, and the Slingsby T-3 Firefly. During his 15-year Air Force career, he has served in various operational and training capacities including the Chief of Cockpit Resource Management (CRM) Plans and Programs at the USAF Air Education and Training Command (AETC). While at AETC, he designed and implemented a comprehensive, career-spanning CRM training system which has radically changed the way that human factors training is offered to all Air Force aviators. Major Kern has been actively engaged in many areas of military aviation training, including inflight instruction and evaluation, academic instruction, and curriculum development. He is a published author and his most recent book *Redefining Airmanship (McGraw-Hill 1997)* describes the traits of historical aviation success over the past 90 years. He holds Masters Degrees in Public Administration and Military History, as well as the Doctorate in Higher Education from Texas Tech University specializing in human factors training and curriculum development. He is currently the Director of Military History at the United States Air Force Academy and lives with his wife Shari and two sons in Colorado Springs.

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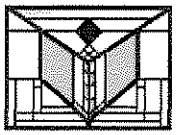

Tim Funari/AGL/FAA
TCL-D21, Detroit TRACON, MI

04/02/2009 10:28 AM

To Jon Jones/ASW/FAA
cc
bcc
Subject Re: ACTION: Request additional meeting with ATO-S representatives

Mr. Jones,

Thank-you,

My work schedule today is from 1300-2100.

Tim Funari
FLM
TCL-D21
o 734-955-5042
c 734-674-0072
tim.funari@faa.gov

To   Tim Funari/AGL/FAA@FAA
cc
bcc
Subject   Re: ACTION: Request additional meeting with ATO-S representatives
Jon Jones/ASW/FAA

04/02/2009 09:08 AM

As I said the offer still stands.

Jon Jones
Quality Assurance, AJS-3200 (TUL)
202 507-1036 (Blackberry)
918 740-7951(cell)

Tim Funari/AGL/FAA
TCL-D21, Detroit TRACON, MI
04/02/2009 08:51 AM

To
Jon Jones/ASW/FAA
cc

Subject
Re: ACTION: Request additional meeting with ATO-S representatives

Mr. Jones,

First, may I refer you to the original message I sent to Mr. Boland, with copy to Mr. Figliuolo (it appears at the bottom).

Second, I am getting lost in the semantic difference between a meeting and a follow-up. In either event you indicated that we would be able to get together today if I chose, and I do so chose. You, of course, have the ability to refuse.

Thank-you,

Tim Funari
FLM
TCL-D21
o 734-955-5042
c 734-674-0072
tim.funari@faa.gov

To   Tim Funari/AGL/FAA@FAA
cc
bcc
Subject   Re: ACTION: Request additional meeting with ATO-S representatives
Jon Jones/ASW/FAA

04/02/2009 08:34 AM

Mr. Funari: I believe what I stated was, if you had additional information such as specific dates, times, call signs of the events we discussed yesterday, or other documents, I would be interested in receiving those items from you. That offer still stands. I did not view that as an additional meeting, but as a follow-up to the one we had yesteday. I regret your characterization of offering, and then withdrawing an offer of meeting.

Jon Jones
Quality Assurance, AJS-3200 (TUL)
202 507-1036 (Blackberry)
918 740-7951(cell)

Tim Funari/AGL/FAA
TCL-D21, Detroit TRACON, MI
04/02/2009 08:19 AM

To
Joseph Figliuolo/AGL/FAA
cc
Thomas Boland/AGL/FAA@FAA, jon.jones@faa.gov

Subject
Re: ACTION: Request additional meeting with ATO-S representatives

Mr. Figliuolo,

The representatives at issue, specifically one Jon Jones (if I have the name correct), said that they would be meeting with the union representatives today, but that they would make time to meet if I felt the need. I am somewhat surprised that they would extend, then withdraw that offer. Would you please forward to them that my request for a follow-up meeting remains.

Thank-you,

Tim Funari
FLM
TCL-D21
o 734-955-5042
c 734-674-0072
tim.funari@faa.gov

To   Tim Funari/AGL/FAA@FAA
cc   Thomas Boland/AGL/FAA@FAA
bcc
Subject   Re: ACTION: Request additional meeting with ATO-S representatives
Joseph Figliuolo/AGL/FAA

04/02/2009 08:44 AM EDT

Mr. Funari,

I just spoke with the ATO-S representatives and they are not looking to meet with you again; however, they did state that if you had some information for them that you spoke about yesterday then you can drop it off to them.

Joe

Tim Funari/AGL/FAA
TCL-D21, Detroit TRACON, MI
04/02/2009 08:39 AM

To
thomas.boland@faa, gov
cc
joseph.figliuolo@faa.gov
Subject
ACTION: Request additional meeting with ATO-S representatives

Mr. Boland,

The subject representatives requested information I was unable to produce yesterday, but am now able to provide. Per their indications yesterday, may I meet with them again today?

Tim Funari
FLM
TCL-D21
o 734-955-5042
c 734-674-0072
tim.funari@faa.gov