

December 13, 2010

Karen P. Gorman, Esq.
Deputy Chief, Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036-4505

Re: OSC File No. DI-08-3138

Dear Ms. Gorman,

Thank-you for providing the opportunity for me to comment on the Department of Transportation's response to your second supplemental information request; as well as for your continued actions in pursuing these matters in the face of what is now clearly evident to be a less than an objective and thorough evaluation of the allegations that I presented.

With regard to your first request to the Department of Transportation (DOT), this, if I may paraphrase says: Here's the data that was destroyed, along with the problem report that Mr. Funari told you about; please review it and tell me if it does demonstrate a loss of appropriate separation, as Mr Funari alleges. Also please revisit Mr. Funari's original allegation and clarify your findings as they relate to this event given a correct understanding of them.

- The DOT's Office of Inspector General (OIG) is **only partially responsive** to your request. While they do clarify that D21 did not protect the missed approach airspace, they do not clarify their original and supplemental findings related to my allegation in this regard. It should have resulted in a finding that substantiates my allegation but they fail to expressly state such. Further they do not address, at all, the discrepancy between this and previous reports. Lastly, while not completely responsive to your requests, and still refusing to substantiate my allegations, they spend allot of time on the "FAA's" efforts subsequent to the investigation to address those unsubstantiated allegations, as if that was what they were asked to investigate.
- Notwithstanding the significant and troubling inconsistencies **within** the first OIG supplemental report (I addressed them in my previously submitted comments), the OIG lets stand, without explanation a blatant inconsistency **among** their supplemental investigative reports. In this second supplemental report they indicate that there **is** protected airspace that a controller is required to protect, saying: "...the controller did not protect the airspace authorized for aircraft N3845G" and "Northwest Flight 2434 entered the airspace that the TRACON controller was to protect..." while in their last supplemental report they quoted an April 21, 2010 memorandum from the Acting Director of Terminal Safety and Operations Support, Tony Mello: "[T]here are no specific requirements for

'protected' airspace for missed approaches and/or holding patterns at satellite airports for which the controller is responsible..." This contradictory investigative reporting is problematic, to say the least. It appears to be the result of the OIG not applying any test to the reasonableness of the FAA assertions; they are simply repeating contradictory FAA statements as their investigative finding. They are not investigating. Didn't it concern them that the FAA does not seem to understand its own rules? They did not challenge the veracity of Mr. Mello's interpretation (they have not at any time, for instance, come back to me to try to understand why I have a contrary view or to see if I may have a cogent argument in disagreeing with Mr. Mello's interpretation; an interpretation that is in direct opposition to JO 7110.65 requirements). In the first supplemental report they just assumed that Mr. Mello's position was better informed than mine. It appears, now, that they have changed that point of view. It appears that after viewing the playback that they had allowed to be destroyed, the "FAA," (I don't know who within the FAA exactly as the OIG does not so indicate), the "FAA" realized that Mr. Mello's interpretation was incorrect and, in fact, agrees now with my assertion that there is an airspace separation requirement and that D21 did not meet it. The OIG then, without any critical thinking, presented the reversed interpretation as an investigative finding. Doesn't the OIG believe this apparent reversal needs explaining? It can certainly create in a reasonable person's mind a concern for the quality and fairness of the investigation. I believe it is referred to as a "loss of impartiality." An organization so adroit in its perceptive ability so as to ascertain then insinuate into the investigation the finding that some sort of evidence suggests my allegations stem from a personality conflict with OM Boland, should have been able to divine something here. They do not. This is because, as with the personality conflict finding, the OIG is simply chewing up and spitting out the view of the people it is supposed to be investigating. I believe a reasonable person, with knowledge of all the facts, would question the impartiality of the OIG investigation. I also believe that the Secretary of the DOT, Mr. LaHood, and the Administrator of the FAA, Mr. Babbitt, ought to be pretty concerned about the Department of Transportation dismissively reducing a whistle-blower's complaint to that of a petty personality conflict; especially when the whistle-blower has been proven correct wherever he has been able to preserve the evidence that the agency allows to be destroyed.

- In my comments on the first supplemental findings I notate the problems with the OIG investigation; suggesting there may be a lack of understanding of my allegations. I feel I was pretty generous in that characterization. I no longer feel that generous. The OIG has proven to me that they are not interested in a fair airing of my allegations. It seems apparent that they are simply repeating the FAA's point of view without investigation. Does the OIG retain the agency's responses to their questions? How similar would they be to the OIG responses? Can you request that information? I include the complete interpretation issued by Mr. Mello on the subject at issue (see Attachment 1). I do this because the OIG, in their previous supplemental finding seems to have culled the quote they did

include to avoid publishing the blatant contradiction within the interpretation itself. The OIG included the following quote:

[T]here are no specific requirements for “protected” airspace for missed approaches and/or holding patterns at satellite airports for which the controller is responsible. Controllers are expected to plan for the possibility of aircraft executing missed approaches or go arounds and are expected to apply standard [air traffic control] separation should such an event occur.

Not only did the investigation not compare this with the 7110.65 requirements that I discuss in my last comments on the subject, they carefully kept from inclusion the very next line of the interpretation:

*All IFR procedures in the United States are designed in accordance with FAA 8260.3, United States Standard for Terminal Instrument Procedures (TERPS), and incorporate both obstacle clearance and **protected airspace throughout the missed approach procedure and at the designated holding pattern. This protection is transparent to the controller** (emphasis added).*

Now, I have been in the business of air traffic control for almost 28 years and I cannot decipher the meaning behind this contradiction, you would think an investigation might want to try to do so. Perhaps paraphrasing the interpretation may help: “The approach procedure the aircraft has been authorized to execute does, in fact, incorporate protected airspace for the missed approach procedure and holding pattern for which the FAA has provided no specific requirements for protecting. The protection is obvious and easy to recognize or can be seen through.” No; paraphrasing does not help. It just makes no sense to say there is protected airspace that is not required to be protected. I do not trust an investigation that carefully removed this from inclusion in the finding; did not include the complete interpretation as an attachment; and appears to be simply regurgitating the FAA’s responses as an investigatory finding.

- Given that the “FAA” seems to have reversed its position on the protected airspace issue, however, does the OIG still think the allegation in that regard is unsubstantiated? You asked this but they apparently do not want to provide an answer. This is especially important as they did not investigate my allegations based solely on reliance on the word of managers that I allege are not reporting the operational errors and deviations; and who they have determined “*did not display adequate knowledge of requirements for separating non-radar aircraft from radar identified aircraft...*” As you know, in their first supplemental report the OIG stated: “*As for how we obtained information during our investigation, we interviewed Detroit TRACON Frontline Managers regarding airspace protection for satellite airports, including a possible missed approach. We **did not** (emphasis added) monitor satellite airports upon learning from TRACON*

managers that missed approaches rarely occur.” Paraphrased, it reads: “We took on blind faith the word of the people alleged to be lying, you know, the ones we were supposed to be investigating, and based solely on that, ended the investigation.” Do they not now see the problem with that methodology? Do they not see that it is biased in their favor and against me? What does it say about the quality / impartiality of the investigation? I wonder if they view my belief that this indicates a biased investigation as some sort of personality conflict. I firmly believe had they looked for scenarios similar to that I presented to them in the January 16 incident (an event provided to them more than a month before their initial report was issued) my allegation as to the failure to protect for the missed approach would have been substantiated, just as it was in the particular instance discussed here. Moreover, the OIG in this latest supplemental report, indicates that the “Central Service Area, Quality Control Group, is **continuing** (emphasis added) to review TRACON operations to determine whether controllers are, in fact, providing non-radar separation.” Why didn’t the investigation do that? How long has the service center been doing this? Is the service center really executing the review or directing the facility to do so? With how many approaches? Why don’t they tell us the methodology and results of those reviews? Do they know? Don’t they want to know? If they are being done at all, I would be surprised if the methodology is sound (see my review of the straight flight audit on page 9). Have they retained the voice and radar data from the reviewed operations? Can I see them? The investigative ethic the OIG applies to my allegations causes me to believe that the investigation is not being conducted with impartiality, and worse, either out of incompetence or intention, is interfering with a truthful examination of the facts while seemingly stalling so as to allow the problem to be corrected, or the rules to be revised, without substantiating the problem in the first place.

- In this second supplemental report the OIG includes many editorial comments intended to minimize the failure and not germane to the issues that you forwarded for investigation. First, I do not believe they were asked to quantify any collision hazard or the likelihood of radar or radio contact; they were asked to investigate facility management’s failure to ensure that the controllers are protecting for a missed approach off of uncontrolled airports in light of the years that I have been bringing our failure to do so to their attention and, moreover, facility management’s malfeasance by approving of the known condition (the conclusion of the service center investigation). The specific collision hazard of the January 16 event at issue is not the safety concern. The safety concern is the hazard that exists with management not enforcing orders and regulations: selective enforcement. The DOT should be aware of the FAA’s own documents relating to its embrace of Heinrich’s Triangle and Crew Resource Management (see attachment 2) as well as those relating to selective enforcement training (which I had provided to them) and the serious consequences of not following our rules that they describe. The editorial comment regarding likelihood inserted into the discussion of increased potential for collision: “*Had N3845G executed a missed approach and, **although unlikely** (emphasis added), the TRACON was unable to establish radio or radar contact with that aircraft, the potential existed for it to*

occupy the same airspace as Flight 2434, thereby resulting in an increased potential for collision,” as well as the footnote stating there was no risk of an airborne collision due to the failure, are qualifiers that have absolutely nothing to do with the allegations I presented. They appear to be aimed at influencing an audience other than ourselves. Why are these minimizing qualifiers inserted? I can see why the FAA would want them included, why the investigators? Are they furthering the FAA’s interests rather than investigating their malfeasance? It calls into question the motivation of the investigators. Alternately, as I suggested previously, they may be simply reprinting the FAA’s response as an investigatory finding. Either explanation, however, is equally disturbing. Further, the goal of Safety Risk Management (SRM) when considering procedures is to create an error tolerant system; follow the procedure and you have added one more layer of defense against a collision. In the immediate case, if the aircraft inbound to the uncontrolled airport was to encounter an electrical failure for instance (as I have witnessed numerous times over the course of my career) it could very well, and usually does, perpetuate a loss of communication and radar identification (two layers of defense down); controllers simply miss seeing aircraft not associated with a data tag far too often. Traffic Collision and Avoidance Systems would be rendered useless as regards the aircraft with the electrical failure (another layer gone). Do not follow the rules, and you remove another layer of defense. Condone not following the rules and you remove another. Do not hold managers accountable for this failure and you remove another. In the scenario of electrical failure noted above, remove these layers and you are left with virtually one defense, the big sky theory: “there is a lot of airspace out there, they probably won’t collide.” The OIG editorial comments detract from this reality, ignore my concerns, appear to be biased in favor of the agency and, as mentioned previously, are totally unrelated to the allegations I presented.

- The OIG, in the above regard, is dangerously close to doing the same thing that I allege the facility did; specifically, making individual judgments as to the safety of an event independent of the rules that are in place to provide the requisite margin of safety. I allege that management said to controllers: “OK, you did not follow the rule; hey, there’s good cheating and there’s bad cheating; I felt it was good cheating, not unsafe, so it’s OK; we don’t need to worry about reporting the operational error / operational deviation that resulted, it was not ugly enough.” The OIG, by bringing the focus on likelihood and steps **imposed** upon facility management after my allegations were known, while ignoring the core issues (does the failure to follow the rule exist and did facility management condone prior to service center intervention), seems to be saying: “OK, let’s not worry about the fact that facility management knew about the failure to separate aircraft the way you are supposed to be doing and did not correct it; since it is ‘unlikely’ to cause a collision, and since the service center has imposed upon them the corrections they failed to apply, we don’t need to worry about their lack of action / complicity in the failures.”

- Any discussion of what the FAA has done to impose upon facility management the corrections they should have long ago instituted are only germane to my allegations in that they support them. The fact that the service center imposed corrections on facility management after determining that management had, in fact, demonstrated approval of the noncompliance, proves the malfeasance of facility management. Perhaps the OIG was just too busy working up that “personality conflict” finding to spend much time on this issue. I made serious allegations as to the failure of facility management to execute their duties with regard for the public trust. The fact that they were forced to correct that failure after my whistle-blower allegations were known adds support to the veracity of the allegations. The OIG seems to say that actions not initiated by facility management, but, rather, imposed upon them, somehow equates to appropriate facility management action. Why does the OIG keep addressing the corrections imposed upon the facility (while not clearly identifying that they were) but not the malfeasance that existed previous to it? It calls into question the impartiality of the investigation. I attach then Acting Administrator, Mr. Robert Sturgell’s December 2008 e-mail on Commitment to Safety, and the Commitment to Safety itself (attachment 3), which stands in stark contrast to what was transpiring at the facility then and in this investigation now. I include a couple of brief excerpts here:

- As civil servants we are holders of the public trust. The taxpayer has the right to expect that our professionalism, dedication and attention to detail will ensure system safety.
- Integrity is our character. We do the right thing, even if no one is looking.
- Executives and managers hold themselves and employees accountable for safety performance.
- Executives and managers communicate openly with employees to keep the paramount focus on safety.
- Executives and managers fairly, openly and respectfully consider, and when appropriate, act on safety concerns reported by employees.

So the OIG ignores the fact that high level management said there is good cheating; they find a failure to report safety events and blame that failure on process; they admit that the second level manager who called a whistle-blower a squealer does not support the reporting of safety events but determine that this is not evidence of a management culture that so fails to support the reporting of them; they ignore so much more. I offered many performance documents to the Department of Transportation investigation. The investigator, Mr. Brian Urega, kept telling me he was not there to investigate allegations of prohibited personnel practices. I told him that I was not asking him to do so. I told him that I was offering them as proof that facility managers were trying to get me to stop reporting the violations of rule and regulation, and, therefore, those attempts speak to the improper management culture. I have offered some of these performance documents in previous comments. I provided many more to the investigation. I believe I have mentioned this one before, but I include it here

because it speaks volumes in light of the fact that the OIG claims that “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...” After years of telling upper management that we were knowingly ignoring our own regulations and either being ignored or told to shut up, I started auditing these events. Below is a documented example of how one attempt to show our failure in identifying and reporting operational errors and deviations was received:

*Tim’s judging of his peers was **not solicited nor welcome** (emphasis added) and has negatively impacted the collaborative relationship that existed between himself and the other FLM’s. In one example, Tim took the opportunity to review the voice and radar data from a QAR not involving his employee or himself, sharing his differing opinion of the employee’s performance while evaluating his peer FLM.*

What is unsaid in this negative performance critique is that this and similar reviews that I conducted resulted in the exposure of many operational errors or deviations as well as other unsafe acts. Yet they were unwelcome. I can not understand how the OIG does not see this as an attempt to influence me not to ensure reporting of air traffic events. Can you? Why do they not think it is evidence of a poor safety culture that does not support the reporting process? This is far from the only example I provided the investigation.

- Further, in minimizing the import of the facility management malfeasance the OIG references a memo that I authored and was successful at publishing **after** the Air Traffic, and District, Manager, Mr. Figliuolo, was interviewed by OIG in conjunction with the investigation of my allegations [this memo, in part, **rescinded** the use of “non-approved alternate missed approach *instructions...*, (OIG’s words)” that were put in place by facility management **before** the OIG investigation]. The OIG seems to be using evidence that supports my allegations to instead minimize them. Mr. Figliuolo was aware of the “non-approved” guidance at the time of issuance; why did the facility guidance change after the interview? Did the interviewers intervene? Could it have simply been the tone of the interviewers? Additionally, the OIG seems to be stating that a reminder that I provided in December 2009 of the February 2009 direction that was **imposed** by the service center to correct management’s failure and to ensure proper protection for a potential missed approach, somehow supports the fact that the facility was seriously trying to correct the issue when the evidence suggests otherwise. The reminder was that a controller must provide non-radar protection for the missed approach segment at uncontrolled airports. The failure to provide appropriate separation identified in the January 16, 2010 event is only a few weeks **after** my December 21, 2009 memo. It, in itself, does nothing to ensure compliance. As I have said many times during the course of this investigation, especially as regards the e-mails designed to provide for the possibility of plausible deniability of complicit actions, the written document says very little about actions to ensure it

is complied with. I suggest that the fact that the direction in my memo was not complied with lends support to my allegations. It is not the written word, but the actions by facility management to foster compliance with the direction that is the issue. There was not compliance, because compliance was not demanded by facility management in a position to do so.

- For all of these reasons the OIG response is deeply troubling, and, at the very least, clearly unreasonable.

With regard to your second request to the DOT, which, if I may paraphrase says this: The investigation conducted by the Central Service Center's Safety Assurance Group concluded that Detroit management had given tacit approval to not reporting operational errors and deviations; can you please clarify why you do not agree with those findings? Also, please provide copies of the reports referenced in the May 2009 memo from ATO Safety investigator Ms. Strawbridge to ATO Safety Director Mr. Bedow.

- The OIG is completely unresponsive to your request. They do not explain why they do not consider the previous investigation's conclusion as evidence that substantiates my allegation as it surely does; they do not provide you with the copies of the reports you requested.
- As you are well aware, before the OIG started their investigation, I informed the Service Center of my allegations. The Central Service Center sent Dorothy Davis of their Safety Assurance Group along with a team to investigate. During her interview of me at that time (early February 2009) I informed her that I had filed a whistle-blower complaint with your office. Interestingly, after that notification, she cancelled her plans to depart the facility and stayed on for an additional period of time. She also offered me a detail to work for her office in the Service Center. Her investigation substantiated that there existed at the facility a management culture that condoned the failure to report errors and deviations. Coincident with this, the Service Center **imposed** direction on the facility in an attempt to correct the issues because of that culture. The OIG does not identify this. Instead they are trying to say that this somehow reflects positively on the facility's managers. I find this suggestion troublesome. It is very misleading. Again, it causes one to question the investigative ethic as well as the impartiality of the investigation. Beyond that, a reasonable person might even think that if not the result of complete incompetence, they are purposely trying to mislead you as they did when they told you in their initial findings that they were reviewing the January 16 error discussed above, when in fact they were not; instead they allowed the evidence to be destroyed.
- Finally, the OIG, again, spends most of its response trying to minimize the issue with a litany of corrective actions that were **imposed** on the facility. While I struggled with the decision to discuss it here because I'm already at the bottom of page 8 and I believe the OIG's emphasis on this is meant to obscure rather than illuminate, you should be aware of this: what they omit is any discussion of

how effective those actions are. Because they do not admit the issue exists to begin with, they don't discuss how effective they are in improving the compliance culture of the facility's managers. So in their response to you the OIG touts the new Quality Assurance Review Directive and Reporting Form (remember they assert the process, not people, was the problem and, therefore, that a new form will fix it). Let me tell you what transpired on Monday of this past week, 12/06/2010. While I was in the TRACON, the arrival end Frontline Manager (FLM) Tom Gill, reported to the departure end FLM, Tom Murphy, that there was a possible operational error on final. The departure end FLM was training a Controller-in-Charge between 1427 and 1656 GMT, Chuck Hopkins, and caused him to place the appropriate entry for a Quality Assurance Review (QAR) on the facility's daily log, the 7230-4. The CIC in training was then instructed to call the Quality Assurance support specialist, Randy Olson, and advise him of the possible error so as to start an investigation. The next day I viewed the log to see if an error was documented. What I found is that any indication that a QAR was initiated was removed from the log (see Attachment 4). Now, the applicable directive, JO 7210.3, directs that, other than spelling or grammar corrections on an automated form, no one is to erase anything (see Attachment 5). What FLM Murphy told me when I asked about this on the 7th is that support specialist Olson returned to the TRACON on the day of the event, told FLM Murphy that there was no loss of separation, and deleted the QAR notation from the daily log, contrary to regulations and in subversion of the QAR process and the applicable reviews. FLM Murphy advised that he reported the incident to Operations Manager (OM) Kevin Grammes, yet the deletion remains uncorrected and the QAR to assess controller performance remains uninvestigated or documented. How much of this type of malfeasance continues, no one can say, especially when they don't admit it exists to begin with. Does this sound like a positive safety culture; one that embraces following regulations? The OIG would have you believe that instances of noncompliance such as this reflect a problem with "process;" I disagree. It reflects, rather, a poor safety culture and a failure to fulfill one's obligations with regard for the public trust, and it continues, uncorrected.

The OIG also touts in this latest supplemental report of investigation, the daily audits conducted by the Quality Control Group to ensure compliance with straight and level requirements, even though it has failed to investigate why non-compliance is not an error or deviation as the agency's directives dictate. The fact that the TRACON's peak traffic is rarely, if ever, between the hours of 11:00 a.m. and 1:00 p.m. aside (on a week long review I conducted, it was almost always between 2:00 p.m. and 4:00 p.m. and never between 11 and 1), let me tell you of something else that transpired this week and speaks to the efficacy of this audit. I have told you in the past (I attach the e-mail titled "An R&I Item Regarding Straight Flight" along with the first page of the R&I item and the applicable paragraph of JO 7110.65 as Attachment 6) that I doubted the accuracy of these audits; again that safety culture problem. On the door of the TRACON this past Thursday, the 9th, an e-mail was posted that had been authored by OM Grammes

on the 8th (see Attachment 7). It boldly touts the audit results of three sessions of simultaneous independent ILS approaches (between 9:11 and 16:21 local on the 7th) that revealed that we were in 100% compliance with the JO 7110.65 requirement to “Provide at least 1 mile of straight flight prior to final approach course intercept,” and, as you know, speaks to one of my allegations. Since these audits were outside the supposed peak hours of 11:00 a.m. to 1:00 p.m., I do not know if this is the daily audit to which the OIG referred. However, it is misleading in suggesting that every aircraft had at least a mile of straight flight immediately prior to final approach course intercept. In fact, there are a total of twelve (12) aircraft that do not have the required period of straight flight, in ten (10) of those instances, it was not provided by the controller; in the other two it was due to pilot errors but the controller did not break the aircraft off of the approach. Given an accurate reading of the requirement that insists that this straight flight be provided in order to use the reduced separation allowed by simultaneous independent approaches, the failure resulted in a minimum of 8 unreported operational errors and 2 unreported operational deviations (I only discuss the 10 controller initiated events and I attach pictures of the events as well as notes on the period of straight flight they actually indicate; see Attachment 8). I did not verify the total number of flights issued simultaneous approach clearances, but accepting the figure of 56 that is indicated in the e-mail at issue, the true compliance rate is 79%, not 100%. At what point do you think the OIG will start to figure out that something other than process issues are to blame for these misrepresentations? Do they not note that every time the facility makes what I will euphemistically call a “mistake” it is to their benefit?

The OIG also states that the facility has been required to conduct more Traffic Analysis and Review Program (TARP) audits than that of other facilities. (By the way, why didn't the OIG find that the facility had destroyed evidence of the audits they were required to perform prior to my whistle-blower complaint being known as I alleged? The Service Center and ATO Safety were aware of this. The OIG must know this, why did they not report it?) As I have demonstrated above, however, TARP can alert all it wants; if the people evaluating the alerts do not do so with regard to the public trust, it's useless. Further, what the Department of Transportation is not telling you is what I found out in a phone conversation with Michael McFadyn. He is a contractor working on TARP for ATO Safety and to whom I was referred when I asked our local quality assurance department about the programs ability to identify errors. He advises that TARP won't alert on many reportable events. For instance, in the case of requirements that dictate aircraft be established on final before transition to reduced separation as required for dependent and independent ILS approaches, TARP is set up in a way that is less restrictive than JO 7110.65 requirements (the 7110.65 requires the aircraft to be “*stable or fixed on a route, route segment, altitude, heading, etc.,*” while TARP allows it to be within 10 degrees of that); it will not alert in those “ticky-tac” losses of separation, as McFadyn put it. Further, because the parameters are not standardized across all facilities, what alerts as a loss of separation at one facility will not alert at another. Does this make any

sense at all? So TARP may help to alert on more losses of separation, but it has the same failure built into it that is at the heart of my allegations of the safety culture at Detroit: if it's not considered that serious, it won't be reported. This may explain why the Department of Transportation's OIG doesn't think facility management fostered a poor reporting culture: at least in the immediate case the FAA is in the process of moving to that same culture. Are they abandoning Heinrich's Triangle? The 7110.65 requires the aircraft to be out of the turn, it does not say in a turn and within 10 degrees of being out of it. The 7110.65 requires at least one mile of flight without any bend, it does not say kind of straight or almost straight flight. I wonder if the Secretary and Administrator are aware of this.

- For all of these reasons the OIG response is deeply troubling, and, at the very least, clearly unreasonable.

With regard to your final request to the DOT, which, if I may paraphrase says this: Given that the QAR directive appeared to be in compliance with FAA Order 7210.56, yet various investigations identified non-compliance in reporting errors and deviations, why do you say it was a problem with process and not with the actions of people charged with executing the apparently correct process? Further, were there any specific individuals associated with the "process" failures?

- Again, the OIG is unresponsive. They make no attempt at all to explain why they made a finding that it was "...the *Quality Assurance Review process within Detroit Metro failed to adequately detect and investigate operational errors and deviations.*" Further, they ignore your request for the specific individuals associated with the supposed process failures, simply quoting their original report that it was "the relevant Frontline Manager."
- I believe that previous comments I have made in this and previous documents address the problem with this part of the investigation.
- I will however, include one more group of documents that I had provided contemporaneously with the event to yourself, and subsequently to the OIG. I had reviewed two QARs which revealed that they had been improperly executed by Frontline Managers and, apparently an Operations Manager. In one a controller unintentionally put an aircraft into conflict with another on a closely spaced parallel runway, and had to correct that mistake with an "immediate turn." An immediate turn, as defined by the 7110.65, is one that is used when compliance is required to avoid an imminent situation. In the other a controller has an operational deviation. In both, the Frontline Manager concluded that no performance deficiencies were identified. What I think you will find interesting in the e-mail string I attach, is the response of the acting staff manager, now acting Air Traffic Manager, to whom I provided the information as part of my whistle-blower actions. While mentioning that they are going to look into the possibility that an OD occurred (an investigation resulted in operational deviation

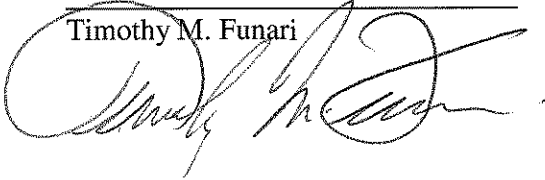
D21-R-09-D-018), Mr. Ancinec says that: *"We have looked into the issues you raised in this memo. In both cases, it appears that the actions taken by the OM or FLM conducting the investigation were correct."* How could they have been correct? They did not identify the safety issue present. This is the culture that existed at the facility 2 months after my whistle-blower allegations were known. Again, the OIG was presented this documentation.

If I can be indulged just a moment or two more while I completely depart from the professional to the human perspective I am, quite frankly, disgusted with the totally incompetent or intentionally obstructionist findings that the Department of Transportation offers as an investigation. When first informed that the OIG would be investigating my allegations, and without knowledge of the specifics of previous investigations by that office, I believed I would get a fair hearing. I no longer believe that. What you are looking at is a case in point as to why so many Americans have a poor view of their government. It sure looks like the Department of Transportation is more interested in protecting its image than in holding itself accountable and / or exposing the truth; exactly what the facility itself was doing and what caused the investigation to begin with. That is not to say that you and your office have not stood in stark contrast to that of the OIG. I appreciate your patience with my profuse comments and hope that you will not allow this shabby investigation to be the last word. I know I can not. I just believe that the taxpayer and the flying public deserve better.

Sincerely,



Timothy M. Funari



- Attachment 1: April 21, 2010 interpretation from Tony Mello on missed approach protected airspace
- Attachment 2: Document excerpts relating to Heinrich's Triangle and Crew Resource Management
- Attachment 3: FAA Administrator Robert Strugell's 2008 e-mail and "Commitment to Safety"
- Attachment 4: December 6, 2010 facility log (7230-4)
- Attachment 5: JO 7210.3 excerpt on 7230-4 forms preparation
- Attachment 6: 11/12/10 e-mail entitled "An R&I Item Regarding Straight Flight, with attachment and 7110.65 reference included"

- Attachment 7: 12/08/10 e-mail entitled "daily straight flight 12/7 100% found on TRACON door
- Attachment 8: Pictures of radar data with notes that prove noncompliance with straight flight requirement, contrary to audit results
- Attachment 9: E-mail string regarding my review of two QARs



Federal Aviation Administration

Memorandum

Date: APR 21 2010

To: Nancy B. Kort
Director, Central Terminal Operations

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

Subject: Request for Interpretation of FAA Order JO 7110.65, Paragraph 7-4-3,
Clearance for Visual Approach; Your memo dated June 17, 2009

We have received your request for both a clarification of an interpretation dated December 26, 1996, as well as your request for guidance on missed approach procedures/instruction and protected airspace. First, the interpretation dated December 26, 1996, is still valid. With that in mind, we offer the following:

First, we wish to re-emphasize the differences pointed out in the 1996 interpretation request that highlighted the distinction between the terms "alternate instructions" and "alternate missed approach procedures." As stated in the interpretation, "alternate instructions" are air traffic instructions given in lieu of the published procedure, whereas "alternate missed approach instructions" are actual missed approach procedures developed by terminal instrument procedures personnel for airports that require more than one missed approach procedure. In answer to your second question, controllers can issue alternate instructions such as "At departure end turn right heading 360, climb and maintain 3000" for separation, safety, noise abatement, operational advantage/efficiency, when a pilot requests or other provisions listed under FAA Order JO 7110.65, Paragraph 5-6-1. However, in doing so, ATC assumes responsibility for appropriate obstacle clearance and must use the tools it has available to ensure obstacle clearance to include minimum vectoring altitudes(MVA), minimum IFR altitudes, or diverse vectoring areas, all of which have been evaluated to ensure the same TERPS obstacle clearance protection. This applies to aircraft conducting both practice approaches and standard instrument approaches. At Detroit Metro, there is sufficient radar coverage to issue alternate instructions to aircraft. At satellite airports, the only requirement for radar coverage is listed under Paragraph 5-1-13 (b) (2) radar service termination.

In response to Part two of your interpretation request, which you titled "Protected Airspace," from a controller standpoint, there are no specific requirements for "protected" airspace for missed approaches and/or holding patterns at satellite airports for which the controller is responsible. Controllers are expected to plan for the possibility of aircraft executing missed approaches or go arounds and are expected to apply standard ATC separation should such an event occur. All IFR procedures in the United States are designed in accordance with FAA 8260.3, United States Standard for Terminal Instrument Procedures (TERPS), and incorporate both obstacle clearance and protected airspace throughout the missed approach procedure and at the designated holding pattern. This protection is transparent to the controller.

The same holds true of aircraft conducting visual approaches. While there is no missed approach procedure associated with visual approaches, the possibility exists that an aircraft conducting a visual approach may lose visual sighting of the airport and executes procedures specified in the Airmen's Information Manual. Such aircraft are to be separated using the provisions of FAA Order JO 7110.65, Chapters 3 through 6, as applicable.


If you have any questions or desire further information, please contact David Dodd, Acting Manager, Terminal Operations and Procedures, at (202) 385-8778.

CRM – THE WHY

Why

Why We Should Use CRM

- Skilled controllers are vulnerable to normal human and system errors.
- Human factors cause or contribute to up to 80 percent of all aviation accidents, and nearly all ATC operational errors.
- Tragic consequences require us to use countermeasures to reduce both the rates and the numbers of errors and accidents

Introduction

Federal Aviation Administration
5

- ⊙ Aviation technology has improved so much that it is rarely the primary cause of an accident. We have better:
 - Aircraft design, construction, and maintenance
 - Weather detection and avoidance equipment
 - Navigation and ATC equipment
- ⊙ Most accidents, and almost all operational errors, are caused or contributed to by normal human and system errors, to which all people – including skilled professionals like controllers, pilots, and maintenance workers – are vulnerable.
- ⊙ Therefore, it is clearly necessary to address human factors.
- ⊙ Human factors include:
 - the unsafe actions of individuals and teams, and
 - the error-prone conditions in systems, which are created and managed by humans.
- ⊙ In a video we will watch shortly, a Blue Angels pilot points out that, “Aviation is not dangerous, it’s just unforgiving.”

Continued on next page


CRM – THE WHY (Continued)

CRM Effectiveness

CRM Effectiveness – It Works!

- “CRM provides a primary line of defense against the many threats to aviation safety.”
- “Considerable evidence shows the effectiveness of CRM.”

Robert Helmreich, Ph.D.
University of Texas Human Factors Research Project

IntroductionFederal Aviation Administration6

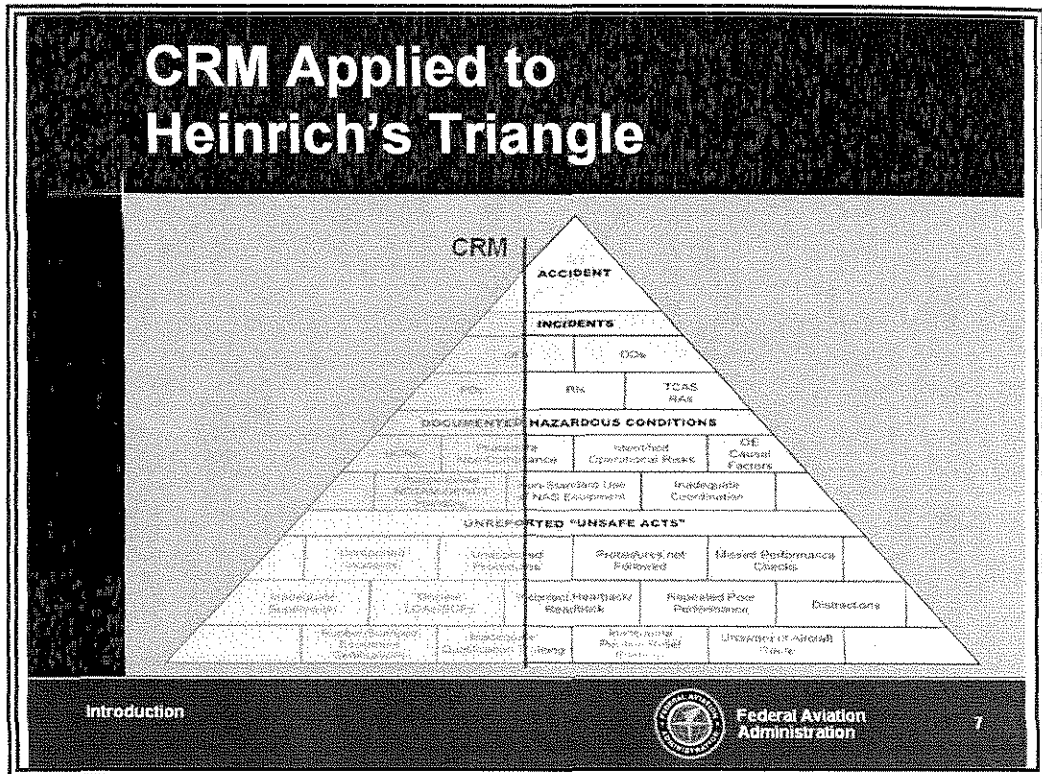
Using CRM Leads to Results

- ⊙ Robert Helmreich and his colleagues at the University of Texas have been internationally recognized pioneers in CRM research, development, and measurement.
- ⊙ Data collected from the airlines and the military consistently show that CRM human factors principles and methods, when actually used in day-to-day operations, do improve safety.
- ⊙ The training field recognizes the importance of transferring learning from the classroom to the operations – liking it, learning it, and using it leads to results.
- ⊙ If up to 80 percent of accidents and almost all operational errors are caused or contributed to by human and system factors –
 - To close the safety gap of human and system factors as the predominant remaining causes of errors and accidents, it is essential to use proven CRM principles and methods in our daily operations.
 - When we focus on and use CRM principles and methods, how can it not make a difference?

Continued on next page

CRM – THE WHY (Continued)

Heinrich's Triangle



- ⊙ The numbers seen on ATO posters of Heinrich's Triangle are not exact, but they make the point that:
 - For the thousands of unsafe acts that are unreported, such as:
 - Not following procedures
 - Distractions
 - Inadequate position relief briefings, etc.
 - There are hundreds of hazardous conditions documented, such as:
 - Operational error causal factors
 - Operational risks
 - Inadequate coordination, etc.
 - And dozens of incidents, such as:
 - Operational errors
 - Operational deviations
 - Runway incursions
 - Which sometimes lead to accidents

TF
7/2009



**FAA
ATO Safety, Operational Safety Services**

Crew Resource Management 101

Self Study Guide

Overview

This study guide is to be used in conjunction with the DVD entitled, "*Crew Resource Management 101*," distributed in June, 2008. The guide is divided into three sections covering Teamwork, Individual Performance, and Threat and Error Management. The guide can be used as a whole in parts for initial, quarterly, or refresher training. Students are advised to view each section on the DVD and in this guide prior to answering the questions at the end of this document. After the DVD, this guide may be used in group discussions or by individuals. The facility should use the proactive data generated to improve the safety culture.

Teamwork

- 1 – In the DVD, COO Hank Krakowski talks about "dissecting" how you work as a team.

- 2 – Professionals in hazardous technologies (where lives are at stake) and other high performance fields (such as athletics and the performing arts) routinely debrief – to reduce errors and accidents, and to improve individual and team performance.

- 3 – Teamwork in ATC requires helping each other, before it is time or safety-critical.

Individual Performance

- 4 – **Higher abilities to maintain situational awareness and execute the plan differentiate experts** from intermediates and novices. Each of us will perform better if we focus our efforts on these two skills.

- 5 – The "**10, 9, 8 tool**" places values – not actual scores – on safe, orderly, and expeditious. In safety-critical decisions, it removes the ambiguity caused by the competing goals of safety and capacity, and helps us to **keep safety first**. It also reinforces the unspoken and thus often-forgotten goal to be **orderly**. If we are orderly, and **put the "C" in ATC** – we will be safe, and as expeditious as we can be in the current conditions.

Threat and Error Management (TEM)

The goal of Threat and Error Management is to identify and eliminate as many individual, team, and system vulnerabilities as possible, and then be wary of and use effective countermeasures against the vulnerabilities that remain.

6 – One vulnerability is the “**Risk Denial Syndrome**” – circumventing standard phraseology or procedures, dropping our situational awareness, or running marginal separation – while thinking, “it won’t matter.” In reality, it’s not a question of if it will matter; it’s only a question of **when** – sooner or later – it **will** matter.”

7 – **Internal risks** (inside the facility) include distractions, incomplete coordination, outdated airspace and procedures, and complex configurations.

-- **External threats** (outside the facility) include weather, flight schedules and traffic volume, complexities with adjacent facilities, language barriers, and pilot capabilities.

8 – The five **CRM error types** (which may be slips, lapses, mistakes, errors in judgment, or system flaws – not necessarily operational errors) are procedural, communications, proficiency, decision-making, and intentional non-compliance.

Remember – those who routinely commit intentional non-compliance errors put themselves in habit patterns to make 25% more errors of the other types.

Self Study Questions

1. In the DVD, COO Hank Krakowski talks about “dissecting” how you work as a team, and the expectation that flight crews will use CRM behaviors for their entire careers. Dissect how your facility and your team use the six CRM Behaviors. Identify positive CRM Behaviors that should be continued or reinforced, and CRM Behaviors that should be changed or done better.

CRM Behaviors to Reinforce

CRM Behaviors to Change or Improve

2. Professionals in hazardous technologies (where lives are at stake) and other high performance fields (such as athletics and the performing arts) routinely debrief, in order to reduce errors and accidents, and improve individual and team performance.

Identify creative ways within your facility, with the resources available, that full or partial teams – people who worked the same session together – can conduct routine team self-debriefs of operational sessions.

Ways to Debrief ATC Sessions with Full or Partial Teams

3. The goal of Threat and Error Management is to identify and eliminate as many individual, team, and system vulnerabilities as possible, and then be wary of and use effective countermeasures against the vulnerabilities that remain.

Internal risks (inside the facility) include distractions, incomplete coordination, outdated airspace and procedures, and complex configurations.

External threats (outside the facility) include weather, flight schedules and traffic volume, complexities with adjacent facilities, language barriers, and pilot capabilities.

Identify the most significant internal risks within your facility and external threats outside your facility, and how you can eliminate or countermeasure them.

Internal Risks

Eliminate or Countermeasure

External Threats

Eliminate or Countermeasure

1.1.2 Setting the Stage: The Importance of Safety

In the context of the SMS, safety is defined as freedom from unacceptable risk. This definition derived from multiple safety definitions. As stated in the Federal Aviation Administration (FAA) Flight Plan, "Safety is our bottom line. It's non-negotiable." Safety must be the principal consideration of all FAA activities.

Heinrich's Triangle is an internationally recognized model that illustrates accident causation. The adaptation of Heinrich's Triangle in Figure 1.1 graphically depicts the relationship between unsafe acts, hazardous conditions, incidents, and accidents. For every catastrophic accident, there are many incidents or minor accidents. For each incident, there are numerous hazards and many unreported unsafe acts. The model states that the most effective accident prevention programs focus on collecting, analyzing, and investigating incident data and the most effective way to prevent accidents is to focus on preventing hazardous conditions before an incident occurs. The SMS allows the ATO to focus on minimizing unsafe acts in order to improve safety. The concept of safety data sharing is covered in detail in Chapter 5, *Safety Promotion*.

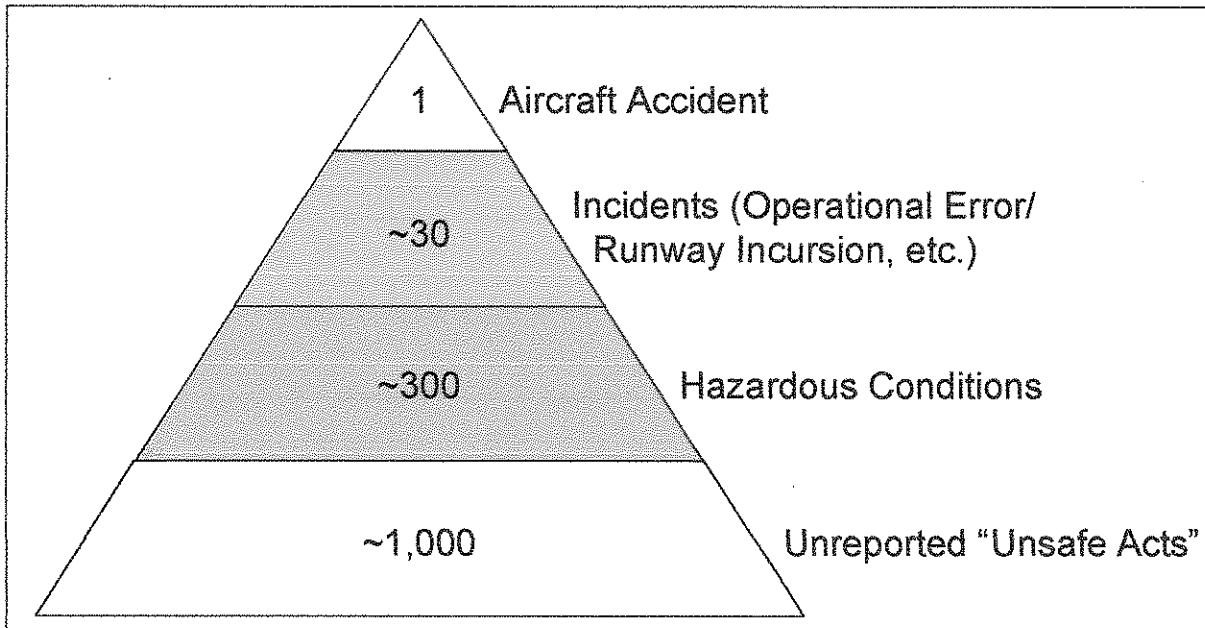


Figure 1.1: The Lesson of Heinrich's Triangle

Note: The quantities represented in Figure 1.1 are for illustrative purposes only and are not based on actual aviation data.

Safety is often equated to meeting a measurable goal, such as an accident rate that is less than an acceptable target. However, the absence of accidents does not ensure a safe system. For each hazardous condition, many unreported unsafe acts or circumstances might exist. Therefore, safety must be constantly monitored and assessed, which the SMS helps to accomplish.

¹ FAA Flight Plan 2008–2012, page 18 (available at http://www.faa.gov/about/plans_reports/).

- e. Accept residual risks prior to change implementation
- f. Implement the change and track hazards to resolution
- g. Assess and monitor the effectiveness of the risk mitigation strategies throughout the lifecycle of the change
- h. Reassess change based on the effectiveness of the mitigations

3.2.3 System, Hazard, and Risk Defined

Three important terms necessary to discuss making NAS changes, the resulting potential hazards, and the management of risk are:

- a. **System:** An integrated set of constituent pieces that are combined in an operational or support environment to accomplish a defined objective. These pieces include people, equipment, information, procedures, facilities, services, and other support services.
- b. **Hazard:** Any real or potential condition that can cause injury, illness, or death to people; damage to or loss of a system, equipment, or property; or damage to the environment. A hazard is a condition that is a prerequisite to an accident or incident.
- c. **Risk:** The composite of predicted severity and likelihood of the potential effect of a hazard in the worst credible system state. Severity, likelihood, and system state will be defined later in this chapter.

The system safety methodology, as described in this manual, addresses risk on an individual hazard-by-hazard basis and, therefore, does not address aggregate safety risk. ATO employees determine risk acceptability using the risk matrix in Figure 3.9.

3.2.4 Defenses in Depth: Designing an Error Tolerant System

Given the complex interplay of human, material, and environmental factors in operations, the complete elimination of risk is an unachievable goal. Even in organizations with the best training programs and a positive safety culture, human operators will occasionally make errors; the best designed and maintained equipment will occasionally fail. System designers take these factors into account and strive to design and implement systems that will not result in an accident due to an error or equipment failure. These systems are referred to as error tolerant. An **error tolerant system** is defined as a system designed and implemented in such a way that, to the maximum extent possible, errors and equipment failures do not result in an incident or accident.

Developing a safe and error tolerant system requires that the system contain multiple defenses allowing no single failure or error to result in an accident. An error tolerant system includes mechanisms that will recognize a failure or error, so that corrective action will be taken before a sequence of events leading to an accident can develop. The need for a series of defenses rather than a single defensive layer arises from the possibility that the defenses may not always operate as designed. This design philosophy is called "defenses in depth."

Failures in the defensive layers of an operational system can be create gaps in the defenses. As the operational situation or equipment serviceability states change, gaps may occur as a result of:

- a. Undiscovered and longstanding shortcomings in the defenses
- b. The temporary unavailability of some elements of the system as the result of maintenance action
- c. Equipment failure
- d. Human error or violation

Design attributes of an error tolerant system include:

- a. Making errors conspicuous (error evident systems)
- b. Trapping the error to prevent it from affecting the system (error captive systems)
- c. Detecting errors and providing warning and alerting systems (error alert systems)
- d. Ensuring that there is a recovery path (error recovery systems)

For an accident to occur in a well designed system, these gaps must develop in all of the defensive layers of the system at the critical time when that defense should have been capable of detecting the earlier error or failure. An illustration of how an accident event must penetrate all defensive layers is shown in Figure 3.1.

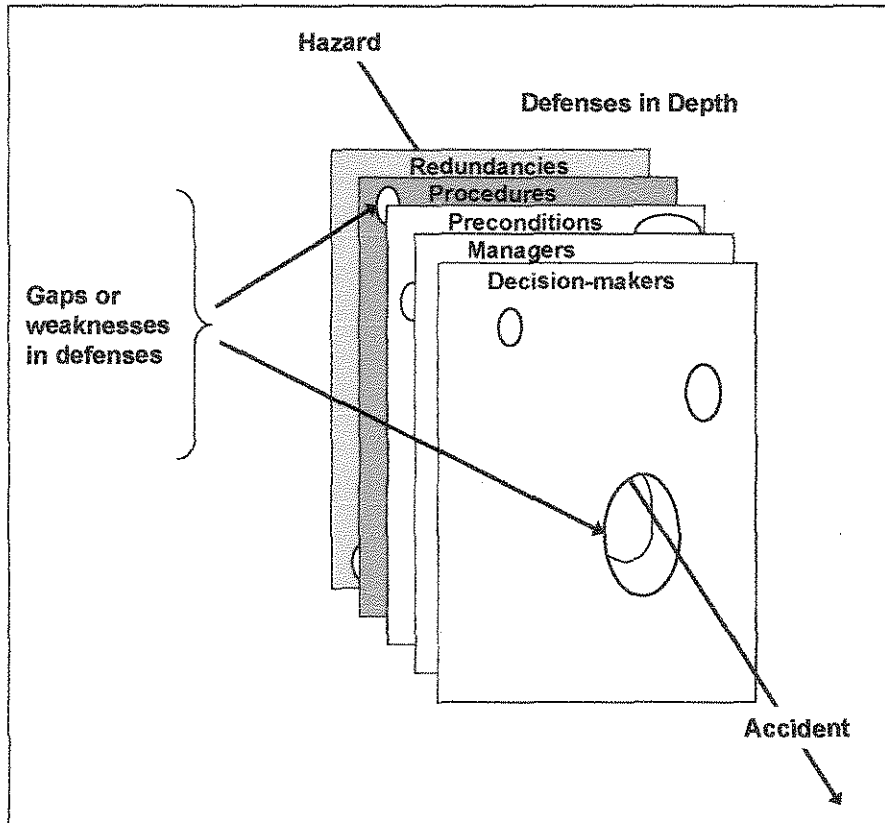


Figure 3.1: Defenses in Depth Philosophy

The gaps in the system's defenses shown in Figure 3.1 are not necessarily static. Gaps "open" and "close" as the operational situation, environment, or equipment serviceability states change. A gap may sometimes be the result of nothing more than a momentary oversight on the part of a controller or operator. Other gaps may represent long-standing latent failures in the system.

A **latent failure** is considered a failure that is not inherently revealed at the time it occurs. For example, when there is a slowly degrading back-up battery that has no state-of-charge sensor, the latent failure would not be identified until the primary power source failed and the back-up

battery was needed. If no maintenance procedures exist to periodically check the battery, the failure would be considered an undetected latent event.

3.2.5 Detecting Gaps

The task of reducing risk can be applied in both proactive and reactive ways. Careful analysis of a system and operational data monitoring make it possible to identify sequences of events where faults and errors (either alone or in combination) could lead to an incident or accident before it actually occurs. The same approach to analyze the chain of events that lead to an accident can also be used after the accident occurs. Identifying the active and latent failures revealed by this type of analysis enables one to take corrective action to strengthen the system's defenses.

3.2.6 Closing Gaps

The following examples of typical defenses used in combination to close gaps are illustrative and by no means a comprehensive list of solutions:

Equipment

- a. Redundancy
 - (1.) Full redundancy providing the same level of functionality when operating on the alternate system
 - (2.) Partial redundancy resulting in some reduction in functionality (e.g., local copy of essential data from a centralized network database)
- b. Independent checking of design and assumptions
- c. System designed to ensure that a critical functionality is maintained in a degraded mode in the event that individual elements fail
- d. Policy and procedures regarding maintenance, which may result in loss of some functionality in the active system or loss of redundancy
- e. Automated aids or diagnostic processes designed to detect system failures or processing errors and report those failures appropriately
- f. Scheduled maintenance

Operating Procedures

- a. Adherence to standard phraseology and procedures
- b. Readback of critical items in clearances and instructions
- c. Checklists and habitual actions (e.g., requiring a controller to follow through the full flight path of an aircraft, looking for conflicts, receiving immediate coordination from the handing-off sector)
- d. Inclusion of a validity indicator in designators for Standard Instrument Departures and standard terminal arrival routes
- e. Training, analyses, and reporting methods

Organizational Factors

- a. Management commitment to safety
- b. Current state of safety culture
- c. Clear safety policy
 - (1.) Implemented with adequate funding provided for safety management activities

3

From: Tim.Funari@faa.gov
Subject: Fw: <p> A Commitment to Safety
Date: December 4, 2008 7:10:27 PM EST
To: tfunari@charter.net

----- Forwarded by Tim Funari/AGL/FAA on 12/04/2008 07:10 PM -----

Bobby Sturgell/AWA/FAA

12/02/2008 01:29 PM

Please respond to
9-AWA-ACO1-Broadcast-Replies

To
cc
Subject <p> A Commitment to Safety

Dear Colleagues:

The Commitment to Safety by FAA employees must always be our top priority.

As civil servants, we are holders of the public trust. The taxpayer has the right to expect that our professionalism, dedication and attention to detail will ensure system safety. We operate, maintain and inspect the largest and most complex transportation system on the planet. It stretches across time zones, continents and oceans.

The magnitude of our task is indeed great. As professionals, we know that there are no shortcuts to safety.

This Commitment to Safety is required as part of an organization's safety management system. It is the same standard to which we hold airlines and the industry at large. We must affirm it every day in the workplace.

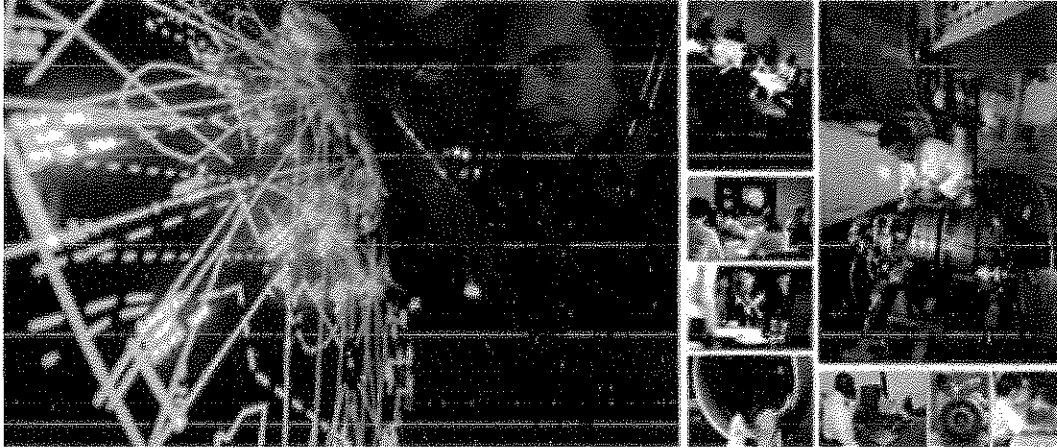
Sincerely,

Robert A. Sturgell
Acting Administrator

https://employees.faa.gov/news/admin_message/safety/

Commitment to Safety

Updated: 10:35 am ET December 2, 2008



Mission

Our mission is to provide the safest, most efficient aerospace system in the world.

Our Core Values

Safety is our passion. We're world leaders in aerospace safety. Integrity is our character. We do the right thing, even if no one is looking. People are our strength. We treat each other as we want to be treated. Quality is our trademark. We serve our country, our customers, and each other.

Principal Elements of Our Safety Approach

Management Commitment

- Starting with the Administrator, all levels of management are clearly committed to serve the public by providing the world's safest aerospace system
- Executives and managers hold themselves and employees accountable for safety performance
- Executives and managers communicate openly with employees to keep the paramount focus on safety
- Executives and managers are committed to continuous improvement and have plans in place to achieve this objective
- Executives and managers provide the necessary training to build and maintain safety leadership skills
- Executives and managers are committed to a safety culture that promotes and supports: safety involvement from all employees, collaboration and partnership programs with stakeholders, and voluntary disclosure reporting and safety data-gathering programs
- Executives and managers create a safe and trusting environment where employees feel comfortable sharing their safety concerns
- Executives and managers fairly, openly and respectfully consider, and when appropriate, act on safety concerns reported by employees

Responsibility & Accountability of All Employees

- Each of us is responsible for maintaining and improving safety for air travelers
- Every FAA employee is committed to safety and is accountable individually and collectively for safety performance
- Safety performance is an integral part of FAA's management/employee evaluation system
- Before starting any regulatory activity or FAA initiative, each employee is required to ensure all safety aspects are considered
- Every FAA employee raises safety concerns to management's attention through appropriate channels
- FAA openly communicates information about safety issues and shares safety lessons with others both in the United States and throughout the world

- FAA sets safety performance goals and conducts regular safety audits to measure safety performance against these goals
- FAA develops proactive safety information analysis and sharing systems to enable early detection of safety problems and measurement of system safety
- FAA develops and applies safety management system (SMS) principles to improve the performance of its safety systems



This page can be viewed online at:
https://employees.faa.gov/news/admin_message/safety/

4

DAILY RECORD OF FACILITY OPERATION				PAGE NO
				Page 1 of 2
LOCATION Detroit, MI				DATE
				Dec 6, 2010
IDENTIFICATION DTW				CHECKED BY
				GARY F. ANCINEC
TYPE FACILITY D21 Front-Line Manager		OPERATING POSITION		
		CHIEF Gary F. Ancinec		
UTC TIME	REMARKS			
0500	K.KIVELA ON, SOUTH FLOW WCLC. CFPL: STARS R17P, SECON LEVEL YELLOW CFPL: DTW-A MODE S STITCHING. SIMUL ILS RY22L NOT AUTHORIZED. (REPORTED OUT 1/11/10) CFPL: THE ASOS FEED INTO THE IDS-4 IS OTS AT YIP, DET, AND ARB. MOCC...DJ. -- KI			
1031	T.GILL ON, ABV NOTED. -- TG			
E 1040	THE ASOS FEED INTO THE IDS-4 IS OTS AT YIP, DET, AND ARB. MOCC...DJ. RTS. -- TG			
E 1057	LIGHT BULB SUPS DESK OTS. -- TG			
E 1158	125.15 MAIN TX OTS. -- TG			
1235	CHI/BOS AIRMETS BROADCAST. -- TG			
1303	WCLC -- TM			
1350	FIRST SIMULS CHQ6017/BTA2360 -- TM			
E 1410	125.15 MAIN TX RTS -- TM			
1420	LAST SIMULS DAL2937/DAL325 -- TM			
1544	BROADCAST BOS & CHI AIRMETS -- CH			
Q 1618	QAR CLOSED N983JC FROM 11/16/10. -- KJ			
Q 1624	QAR CLOSED AWE1048 FROM 11/17/10 ON 11/23/10 LOG. D21-R-109-P-026 AND D21-R-10-E-024 FILED. -- KJ			
1626	FIRST TWO SIMULS @ 1551Z COM652/CPZ5828 AND LAST TWO FLG3696/FLG4075. -- TG			
Q 1637	QAR CLOSED DAL2521 FROM 11/18/10. -- KJ			
E 1644	TDWR OFM 16-20Z -- CH			
Q 1651	QAR CLOSED N189MC FROM 11/18/10. -- KJ			
Q 1700	QAR CLOSED N382MB FROM 11/18/10. -- KJ			
Q 1705	QAR CLOSED DAL1737 FROM 11/22/10 D21-R-10-E-025 FILED. -- KJ			
1800	S. MACK ON, ABV NOTED. -- HB			
Q 1850	QAR CLOSED DAL1737 (TCAS) FROM 11/22/10. -- KJ			
1917	FIRST SIMULS: FLG3746/FLG4012. -- HB			
1940	LAST SIMULS: DAL2920/FLG3907. -- HB			
I CERTIFY that entries above are correct, that all scheduled operations have been accomplished except as noted, and that all abnormal occurrences and conditions have been recorded.		SIGNATURE(S) OF WATCH SUPERVISOR(S)		

DAILY RECORD OF FACILITY OPERATION				PAGE NO
				Page 2 of 2
LOCATION				DATE
				Dec 6, 2010
IDENTIFICATION				CHECKED BY
				CHIEF Gary F. Ancinec
LOCATION		IDENTIFICATION	TYPE FACILITY	OPERATING POSITION
Detroit, MI		DTW	ATCT	D21 Front-Line Manager
UTC TIME	REMARKS			
E 1946	TDWR RTS -- HB			
Q 1958	QAR CLOSED SKW496R FROM 11/22/10. -- KJ			
E 2003	LIGHT BULB SUPS DESK RTS. -- HB			
2100	WCLC. T. KUHN ON ABV NOTED. -- KN			
2104	BOS AND CHI AIRMETS BCST -- KN			
2115	FIRST SIMUL'S DAL242/FLG4162 -- KN			
2140	LAST SIMUL'S DAL2466/FLG3947 -- KN			
E 2240	ARRIVAL END OF ROOM FREEZING COLD WHILE SATELLITE END OF ROOM IS OVERLY WARM - HUGE TEMP FLUCTUATION (MOCC/HM). (AT 2304 MV FROM MOCC CALLED AND WANTED THIS ITEM CLOSED OUT. HE STATED THAT THEY HAVE PREVIOUSLY HAD THE HEATING EQUIP TESTED AND EVERYTHING IS NORMAL THAT THE TEMP FLUCTUATION HAPPENS THIS TIME EVERY YEAR). -- TD			
2259	FIRST SIMULS: DAL2077/FLG3679. -- TD			
2320	S. MACK ON, ABV NOTED. -- HB			
2356	LAST SIMULS: COM618/DAL2299. -- HB			
Q 0107	QAR INITIATED, DAL2854 GO AROUND DUE TO BEING "TOO HIGH ON APCH." -- TD			
0115	T. KUHN ON, ABV NOTED -- KN			
0129	FIRST SIMULS, ASQ5355 & FLG3846 -- TD			
0155	LASTS SIMULS FLG3839 & DAL1022 -- TD			
0215	NORTH FLOW -- KN			
0250	BOS AND CHI AIRMETS BCST -- KN			
0330	R. LINDMAN ON, ABV NOTED -- LR			
0415	T.FRUTOS ON, ABV NOTED. DTW/D21 AIRSPACE REALLOCATION: D21 CONTROLS THE CAGE FOR MID OPS UNTIL 1030Z ON 12/7/10. -- FS			
E 0420	HEATING AT ARRIVAL END AND DEPARTURE END OF TRACON APPEARS TO BE NORMAL, MOCC NOTIFIED. -- FS			
0435	E.HALLER ON, ABV NOTED. -- EH			
0459	COB. -- EH			
I CERTIFY that entries above are correct, that all scheduled operations have been accomplished except as noted, and that all abnormal occurrences and conditions have been recorded.			SIGNATURES(S) OF WATCH SUPERVISOR(S)	

5

Section 6. Records

4-6-1. FACILITY RECORDS MANAGEMENT

Manage facility records in accordance with FAAO 1350.15, Records Organization, Transfer, and Destruction Standards.

4-6-2. COLLECTION OF OPERATIONAL DATA

a. Air traffic managers are responsible only for the routine collection and reporting of basic operational information as authorized in this order or by the appropriate service unit. Collection of any data shall be considered a secondary function and shall not interfere with the accomplishment of operational duties.

b. Air traffic managers shall not permit their facilities to participate in special studies and surveys nor agree to the use of facility personnel to tabulate, prepare, or forward to outside organizations or parties any special summaries, abstracts, reports, or aeronautical data unless approved in advance by the Service Area office.

4-6-3. FORMS PREPARATION

a. Exercise care when preparing forms to ensure neatness and accuracy. The forms are a part of the facility's permanent records and subject to review by authorized personnel or agencies.

b. Except as in subpara c, do not erase, strikeover, or make superfluous marks or notations. When it is necessary to correct an entry, type or draw a single horizontal line through the incorrect data, initial that part of the entry, and then enter the correct data.

c. When using an automated Form 7230-4, grammatical and spelling errors may be corrected by use of delete or type-over functions. Substantive changes in contents of remarks should be accomplished by a subsequent or delayed entry. If the computer software used contains a strikeout feature, this feature may be used.

d. Authorized FAA abbreviations and phrase contractions should be used.

e. New daily forms shall be put into use at the start of each day's business.

4-6-4. FAA FORM 7230-4, DAILY RECORD OF FACILITY OPERATION

a. Each air traffic facility shall use Form 7230-4, or an approved automated version of the form. Air traffic managers shall decide whether to use one set of forms to describe the entire operation of the facility or individual sets for smaller units of the facility, such as sectors, air-ground positions, telecommunications positions, etc. An example of the Daily Record of Facility Operation follows this section. (See FIG 4-6-1.)

b. Use of an automated version of Form 7230-4 must be approved by the appropriate Service Area office prior to the form being used by the facility.

c. The use of FAA Form 7230-4 for individual position assignments is authorized only for the STMCIC, FLMIC, OMIC, TMC, TMCIC, and CIC positions, and positions at the ATCSCC.

4-6-5. PREPARATION OF FAA FORM 7230-4

Personnel responsible for preparation of the Daily Record of Facility Operation, FAA Form 7230-4, shall ensure that entries are concise, yet adequately describe the operation of the facility, including any abnormal occurrences. Prepare FAA Form 7230-4 as follows:

a. Use of a typewriter, computer printout, or ink is mandatory. Signatures or handwritten initials shall be in either blue or black ink. Handwritten entries shall be printed, rather than in script. REMARKS section entries shall be single-spaced.

b. Make all time entries in UTC, except that in the section titled "Personnel Log," local time shall be used for time and attendance purposes.

c. Complete the information required at the top of each form.

d. Make an appropriate notation under "Operating Position" to indicate the extent of the operation described on each form; e.g., "AM," "All," "Sector D3," etc.

e. The first entry in the REMARKS section of each day's form shall indicate the employee responsible for the watch and shall be used to show carry-over items. Items to be carried over from the preceding "Daily Record of Facility Operation" are those which will affect the current day's Daily Record (e.g., equipment outages, runway or airspace status, or coordinated routes/procedures). The last entry on each day's form shall indicate the close of business (COB), consider midnight local time or facility closing time, if earlier, as the close of the day's business.

f. Employees shall sign on/off as follows:

1. When a typed or handwritten FAA Form 7230-4 is used, the employee assuming responsibility for the watch shall sign on using their operating initials and shall sign the certification statement at the bottom of the form.

2. When an automated FAA Form 7230-4 is used, in lieu of actually signing the form, the employee assuming responsibility for the watch shall sign on using their name, e.g., "1430 J. SMITH ON." Entering the name of the employee assuming responsibility for the watch, in lieu of entering operating initials, serves the same purpose as signing the certification statement at the bottom of the actual form. Additionally, the employee responsible for the watch at the time that the form is printed out shall sign the certification statement at the bottom of the form, as when the actual FAA Form 7230-4 is used.

3. When FAA Form 7230-4 is used to indicate position responsibility, record employees initials and exact minute on/off the position.

g. Establish and post a list of equipment checks required during each watch; e.g., recorder checks, siren check, DF net check, etc. Make an entry ("WCLC") on FAA Form 7230-4 when the watch checklist has been completed. Notify the organization responsible for corrective action on equipment malfunctions. Record equipment malfunctions, equipment released for service, notification information and/or course of action taken to correct problem, and return of equipment to service. Facilities may establish local forms and procedures for recording and disseminating equipment malfunction and restoration information. Local forms used for recording this information are considered to be

supplements to FAA Form 7230-4 and shall be filed with it.

NOTE-

At facilities which are closed prior to the beginning of the new business day, changes in status can occur during nonoperational hours. If the status of equipment or other facility operations has changed from status reported on previous days' FAA Form 7230-4, changes shall be noted in Watch Checklist entry, as well as time of status change, if known (e.g., WCLC - ABC VOR RTS 0700). If necessary, place an "E" in the left margin as prescribed in para 4-6-5, Preparation of FAA Form 7230-4.

h. FAAO 7210.56, Air Traffic Quality Assurance, defines situations requiring a Quality Assurance Review (QAR) and the procedures to be followed to accomplish the review. Promptly notify personnel responsible for conducting the review upon identifying the need for a QAR. Record QARs with the minimum detail necessary in order to identify the initiating incident (e.g., unusual go-around) and how it was identified (e.g., in-flight evaluation). Facilities may establish local forms and procedures for recording, disseminating and documenting the resolution of QARs. Local forms used for recording this information are considered supplements to FAA Form 7230-4 and shall be filed with it.

i. Place a large letter "E" in the left hand margin beside entries on equipment malfunctions. The "E" shall also be used when equipment is restored to service. The "E" is not required for facilities using local forms if procedures are established in accordance with subpara g.

NOTE-

The "E" is to be used on entries related to equipment problems which require Technical Operations involvement. The "E" is not required for routine maintenance items or for carryover entries on previously entered equipment malfunctions.

j. Place a large letter "Q" in the left hand margin beside QAR entries. Resolution of QARs, made in accordance with FAAO 7210.56, Air Traffic Quality Assurance, shall be indicated by either the responsible person initialing and dating the original "Q" entry, or by a second "Q" entry identifying the incident and person responsible for accomplishing its review. It is not necessary to document the details of the review or corrective actions taken in these log entries provided the persons resolving the QAR maintain adequate notes and records so as to reasonably explain the QAR at a later date. The "Q" is not required for facilities using local forms if

procedures are established in accordance with subpara h.

k. When this form is used to describe the operation of radioteletypewriter and radiotelegraph circuits, record the following information:

1. Frequencies being used and type of watch (continuous or scheduled) being maintained on each frequency.

2. A record of each communication, test transmission, or attempted communication except when such information is recorded elsewhere in the facility, the time the communication is completed, the station communicated with, and the frequency used.

l. Employees other than the person responsible for the watch who make an entry shall initial or enter initials for each of their own entries.

m. Use additional forms as necessary to complete the reporting of the day's activity.

n. Make an entry closing out FAA Form 7230-4 at the close of business.

o. The air traffic manager, or his/her designee, shall initial the form after reviewing the entries to ensure that the facility operation is adequately and accurately described.

4-6-6. FAA FORM 7230-10, POSITION LOG

a. Air traffic managers shall ensure that FAA Form 7230-10, Position Log, or an automated sign on/off procedure is used for position sign on/off. FAA Form 7230-10 shall be prepared daily. All logs, including automated ones, shall reflect 24 hours or the facility's official operating hours, if less than 24 hours daily.

b. Position logs shall be used as the sole-source record for on the job training instructor (OJTI) and evaluator time and premium pay. As a supporting document for time and attendance (T&A) purposes, position logs which document on the job training (OJT) time shall be retained for one year prior to destruction.

c. Prepare FAA Form 7230-10 as follows:

1. Field 1 shall contain the facility three-letter identification code.

2. Field 2 shall contain a position identifier that is a maximum of five letters and/or numbers, starting in the first space on the left side of the field. Unused spaces shall be left blank.

(a) ARTCCs: ARTCCs shall use sector identifiers which have been approved by the En Route and Oceanic Area Office.

(b) TERMINALS and FSSs/AFSSs: When there is more than one position of a particular type, establish and use individual identifiers for each position. When only one position of a particular type exists, this field may be left blank.

3. Field 3 shall contain a maximum of two letters to show the position type, as follows:

(a) ARTCCs: Starting on the left side of the field, use position codes as follows:

TBL 4-6-1

Field 3 - ARTCC

<i>Designator</i>	<i>Position</i>
A	Assistant Controller
D	Non-Radar Control
F	Flight Data
H or RA	Handoff, Tracker or Radar Associate
R	Radar Control
TM	Traffic Management
O	Other Positions

6



INFO: An R&I Item Regarding Straight Flight
Tim Funari to: Gorman, Karen
TCL-D21, Detroit TRACON, MI

11/12/2010 08:29 AM

Karen,



Straight Flight Compliance.pdf

Although they do not keep me in this loop anymore, I found this in the read and initial binder for the TRACON. I only copied the first page, the first paragraph of which addresses the subject issue. Improvement aside, and if the audits are correct (which is a big leap of faith) this documents the failure to report 52 operational errors or deviations (depending on how close the aircraft got to the aircraft on the parallel approach, 7110.65). This, apparently, over a three week period. Again, please remember that if any of the other requirements of 7110.65, 5-9-7b were not met, the operational error / deviation would not be in question. Have they ever explained why it is in the immediate case (5-9-7b4)?



Federal Aviation Administration

OM UPDATE 11-10-10

DATE	11/10/10
TIME	
DURING SHIFT	<input checked="" type="checkbox"/>
GIS	
Remove on	11/10/10
Originator	
Copies to	✓

STRAIGHT FLIGHT

Outstanding effort by all!

In an attempt to validate where we are as a facility instead of a 2 hour snapshot each week each simultaneous ILS session for the past 3 weeks has been reviewed in regards to straight flight.

Of 1148 total aircraft operations 1096 (95.4%) were found meeting the requirements.

The most significant trend identified has been at the beginning and end of the rush or periods when traffic demand is not high the turns on base to join are too close to the dual bar thus not enough room to meet the 1 mile straight flight before intercepting. Just a little more patience in this area is all that is needed. 26 of the 34 arrival controllers (certified or training) have been reviewed at least once, and without question it appears everyone is making the required adjustments in an attempt to meet the mile straight flight and allow the pilot to set up for a "stabilized approach." This information is being shared with those folks providing the oversight as well, I am confident we can show that the dedicated employees at the facility have made adjustments in this area and this will be a permanent way we do business.

Keep up the great work!

AIRSPACE CHANGE TRAINING

Cliff has published the schedule regarding the upcoming training in support of the airspace changes. As part of the Safety Risk Management, the implementation and training plan was developed and reviewed by the group Implementation is expected the week of Jan. 23, 2011.

The game plan for training is as follows:

On or before Dec. 1st there will be a self guided power-point presentation covering the airspace changes that each employee will be provided time to complete.

Beginning Jan. 2nd each employee is scheduled for classroom training that will cover the changes in airspace, SOP's and LOA's. This training will be conducted by Raytheon (Dennis Slater) with support from members of the airspace safety risk management panel.

b. The following conditions are required when applying the minimum separation on adjacent dual or triple ILS/MLS courses allowed in subpara a:

1. Straight-in landings will be made.
2. ILS, MLS, radar, and appropriate frequencies are operating normally.
3. Inform aircraft that simultaneous ILS/MLS approaches are in use prior to aircraft departing an outer fix. This information may be provided through the ATIS.
4. Clear the aircraft to descend to the appropriate glideslope/glidepath intercept altitude soon enough to provide a period of level flight to dissipate excess speed. Provide at least 1 mile of straight flight prior to the final approach course intercept.

NOTE-

Not applicable to curved and segmented MLS approaches.

5. An NTZ at least 2,000 feet wide is established an equal distance between extended runway final approach courses and shall be depicted on the monitor display. The primary responsibility for navigation on the final approach course rests with the pilot. Control instructions and information are issued only to ensure separation between aircraft and to prevent aircraft from penetrating the NTZ.

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

Tim Funari
Support Manager (Acting)
TCL-D21, Detroit Approach Control
o 734-955-5007
c 734-674-0072
f 734-955-5289
tim.funari@faa.gov

7

daily straight flight 12/7 100%

Kevin Grammes
TCL-D21, Detroit TRACON, MI

Tom M...
Sawyer...
Gill...
Tibby D...

Northflow

3 sessions

55 total aircraft
56 met requirements

GS
RR
MDEL * FIRST SIMUL SESSION!
RH
KC
LR

ALL 100%!!!!

Kevin J. Grammes
Operations Manager, D21 TRACON
(Office) 734-955-5025
(Cell) 917-403-9345

171

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Executive Committee
1207 1000 / Strategic Rights 1000

Tom Murphy, Tom Kato, Robert J.
Gordon, Dan Murray, Thomas F.
Cott, Paul Smith, Cliff Auer,
Terry D. Carter, Steven A. Mace

1207 1000 / 1000

Director

Executive

Chairman

Chairman

VP

VP

VP - Strategic Business Development

VP

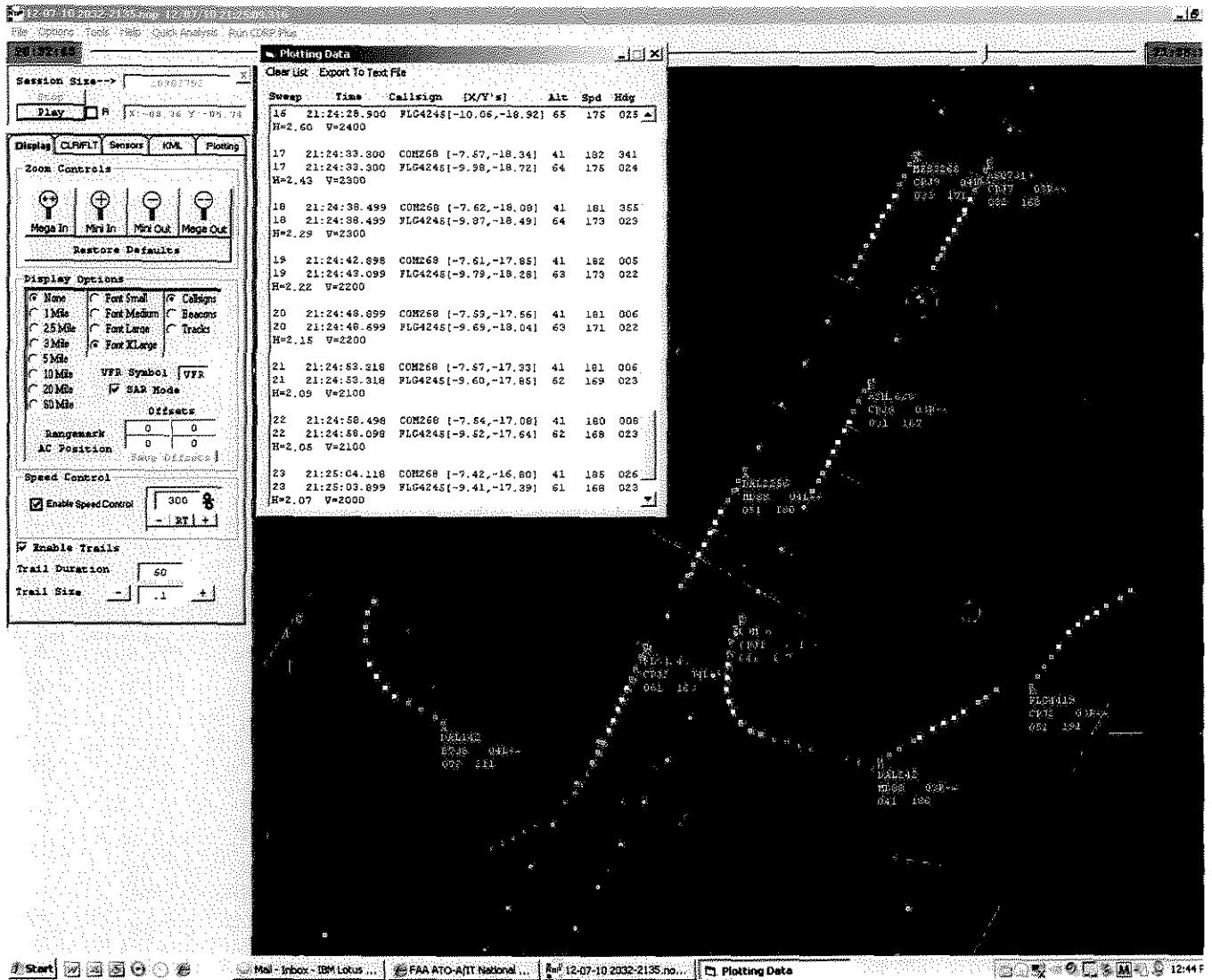
VP

VP

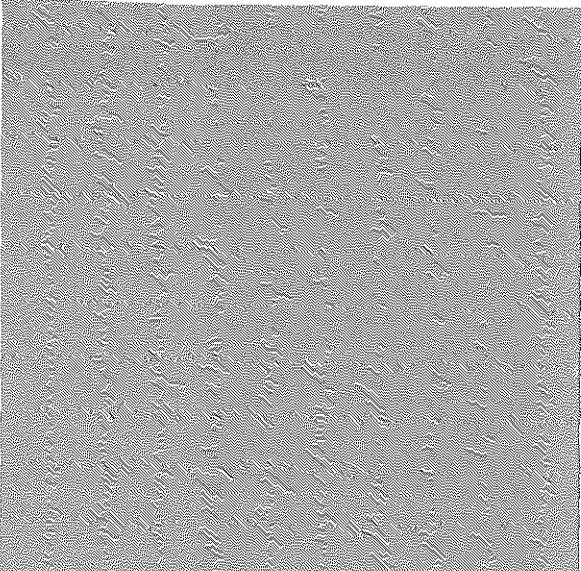
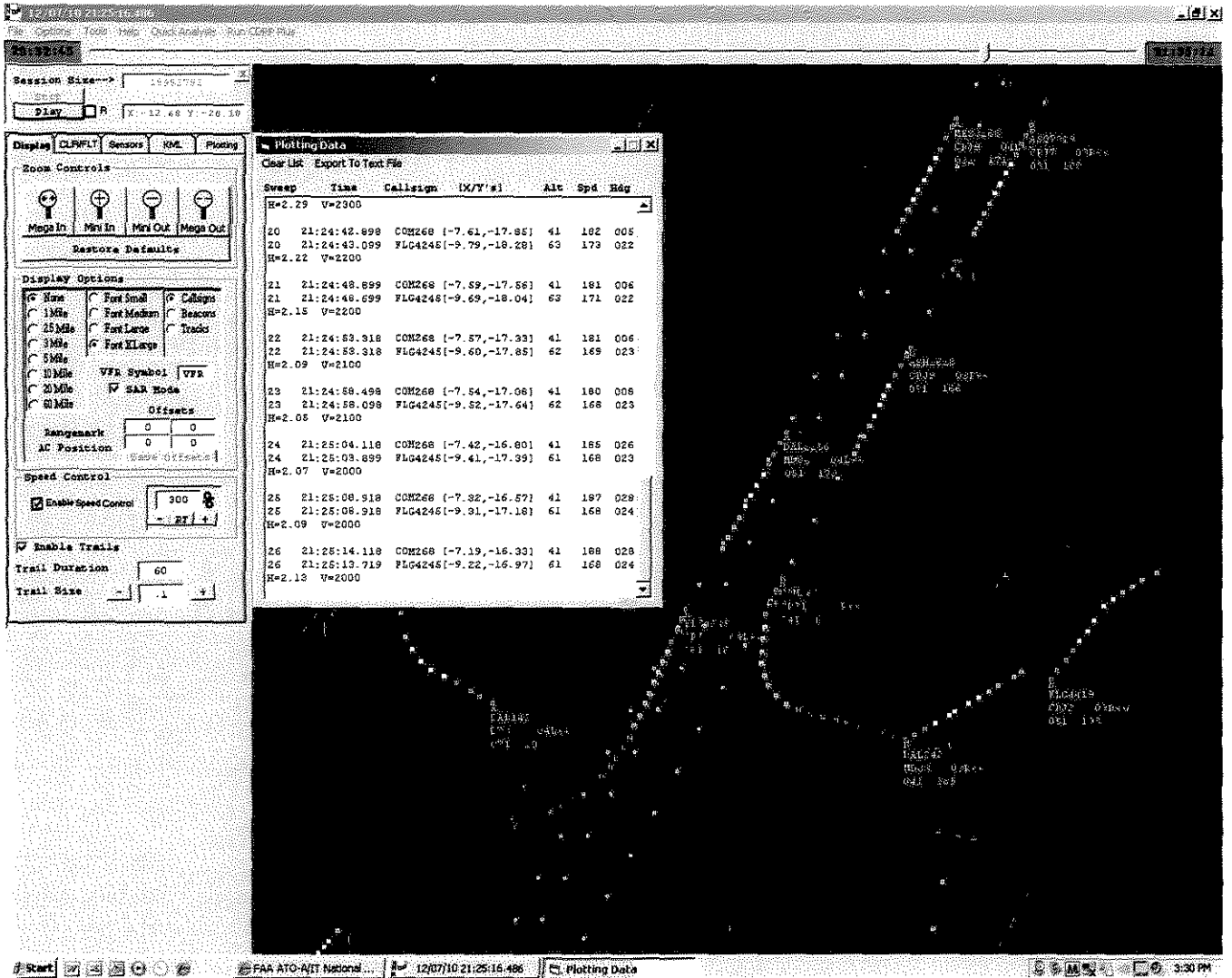
All positions

Strategic Rights
Executive Committee 1207 1000
Phone: 704-991-0000
Fax: 704-991-0000

1217110
100%



If you go as far as
 to think that a
 3° turn is straight,
 @ the fastest speed,
 of 182 kts =
 10.76 nm



Session Size--> 49962762
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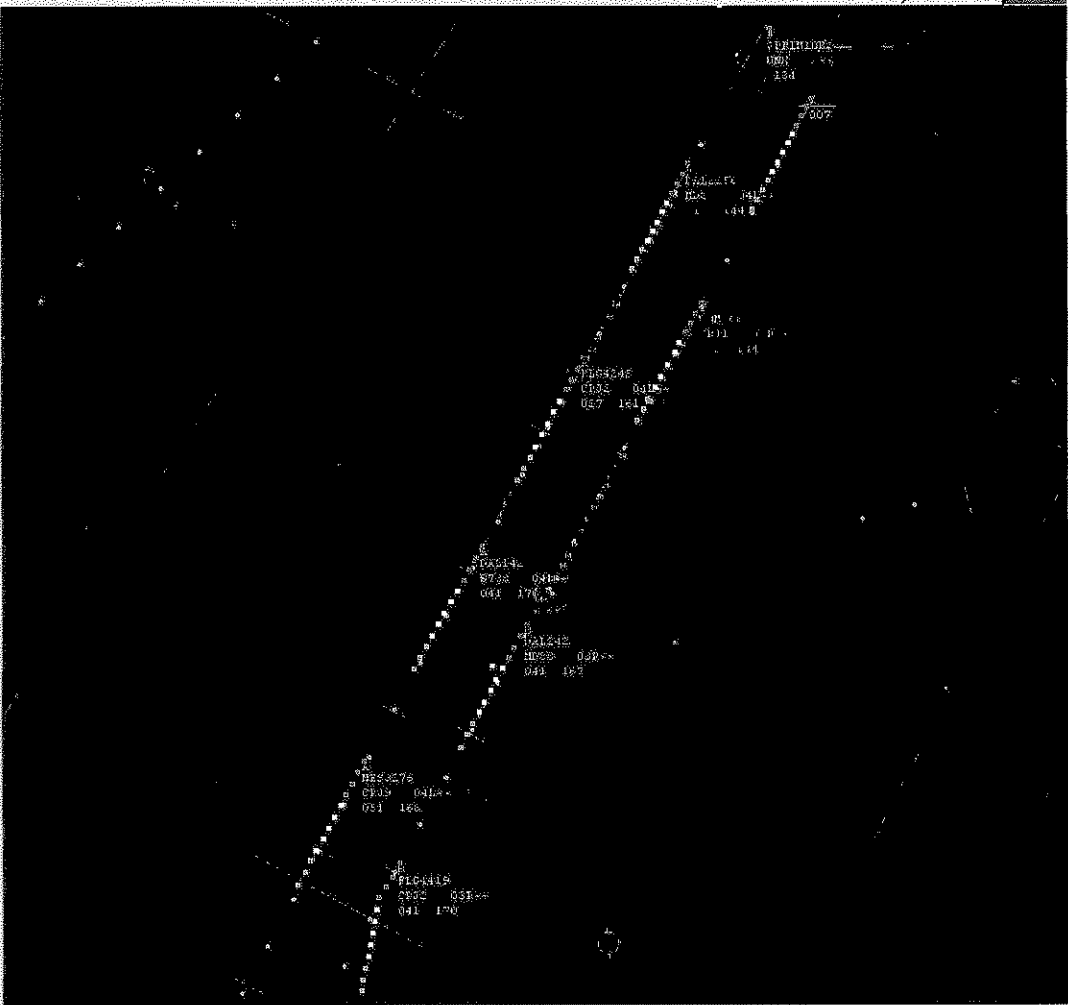
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Zoom Controls
 Mega In Mega Out
 Restore Defaults

Display Options
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 1Mile Font Medium Beacon
 25Mile Font Large Tracks
 3Mile Font XLarge
 5Mile VFR Symbol VFR
 10Mile SAR Mode
 20Mile Offsets
 50Mile
 Rangesmark: 0 0
 AC Position: 0 0
 Save Offsets

Speed Control
 Enable Speed Control 300
 - RT +

Enable Trails
 Trail Duration: 60
 Trail Size: .1



Session Size: 1898702
 Play R 21-07-20 Y--09-63

Display CLPFLT Sensors KML Plotting

Zoom Controls
 Magn In Magn Out
 Restore Defaults

Display Options
 None Fox Small CallSigns
 1Mile Fox Medium Seasons
 25Mile Fox Large Tracks
 5Mile Fox XLarge
 10Mile VFR Symbol VFR
 20Mile SAR Mode
 60Mile

RangeMark: 0 0
 AC Position: 0 0

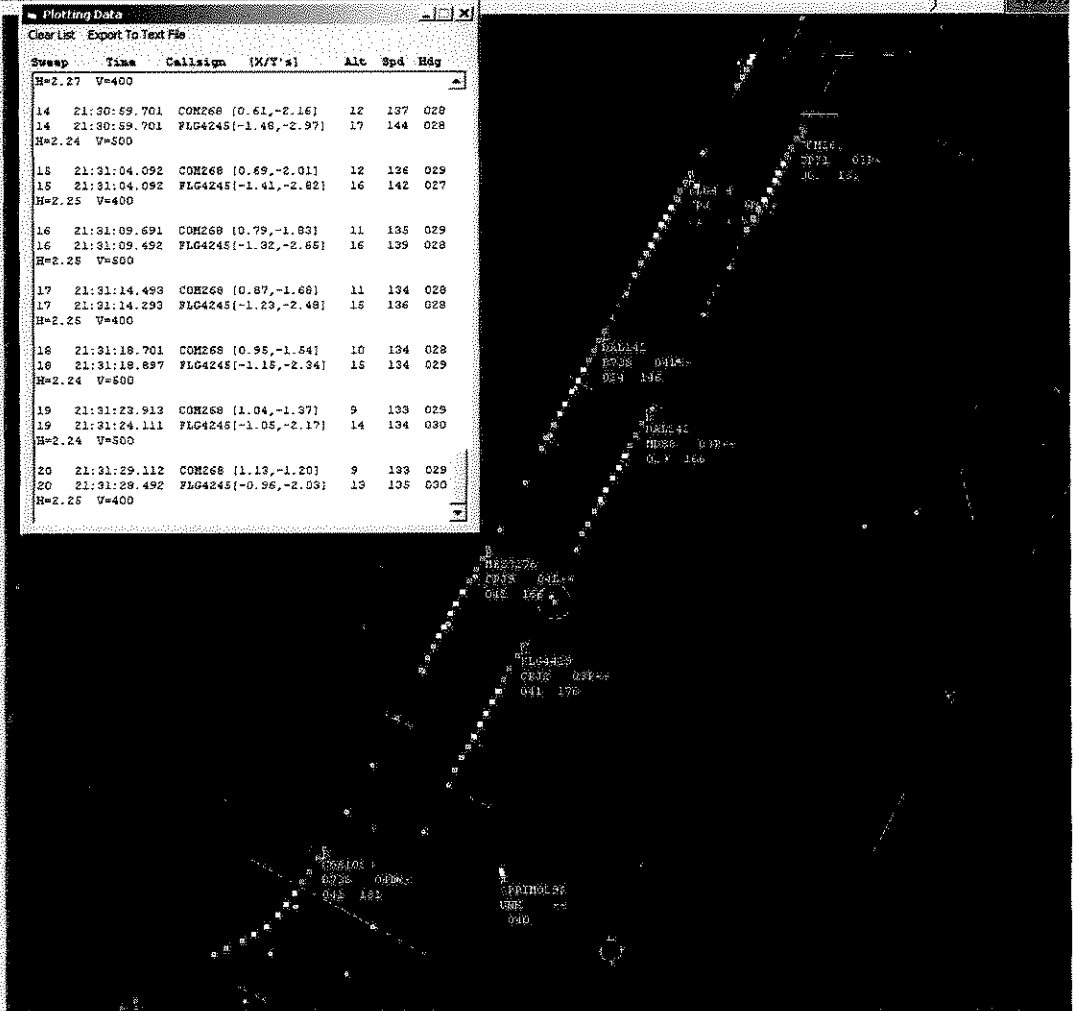
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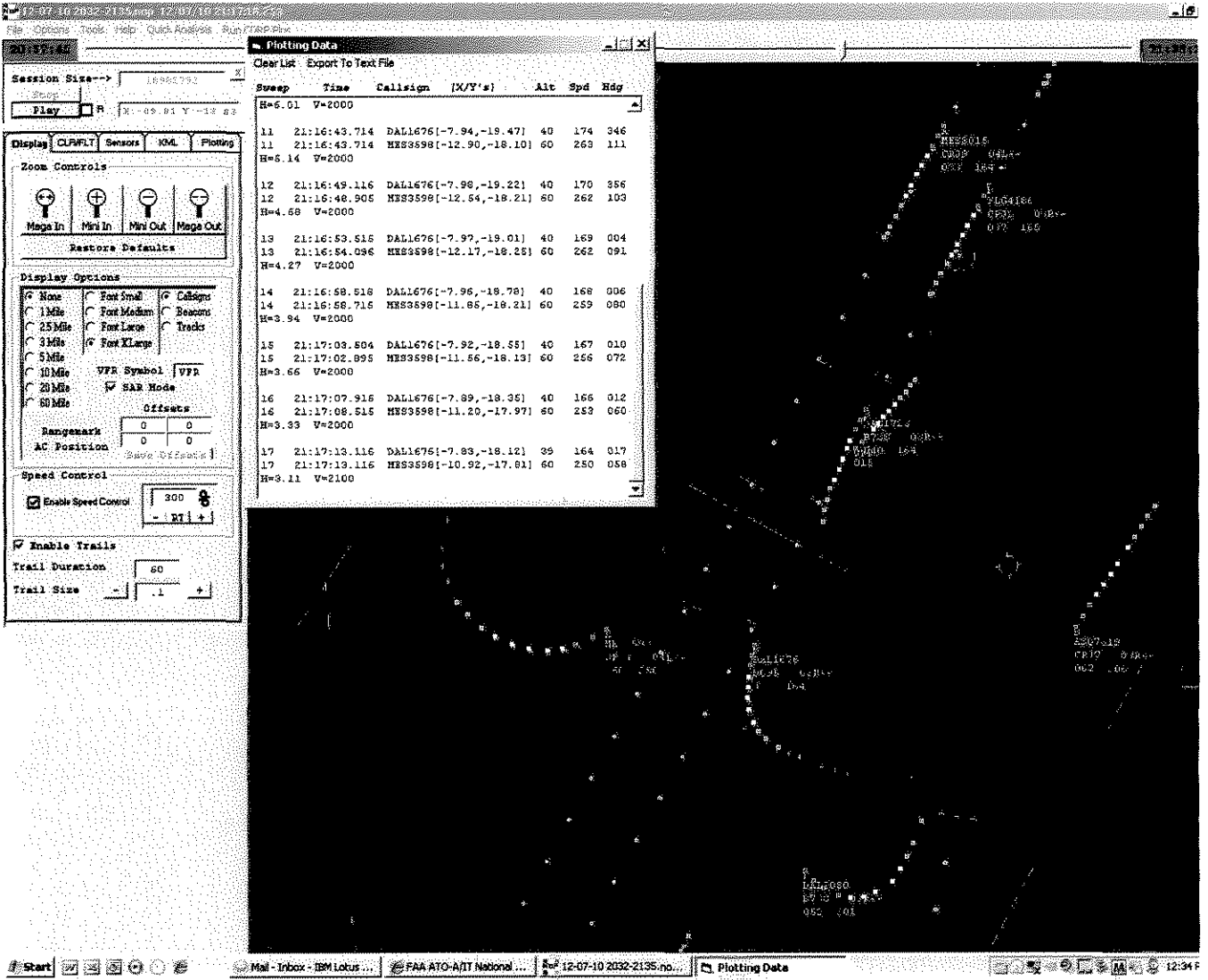
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Plotting Data

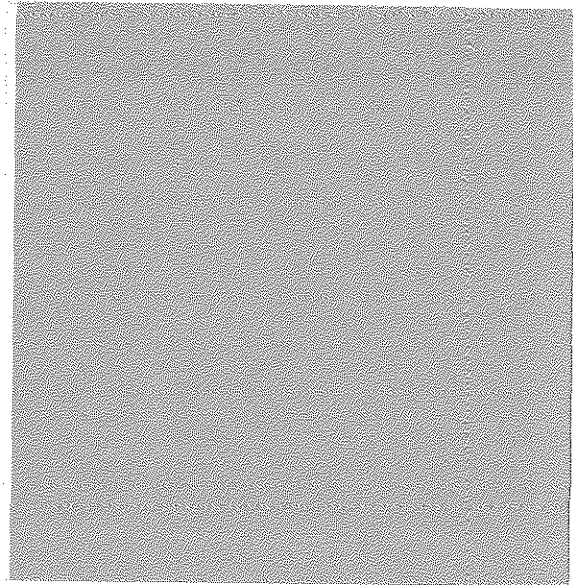
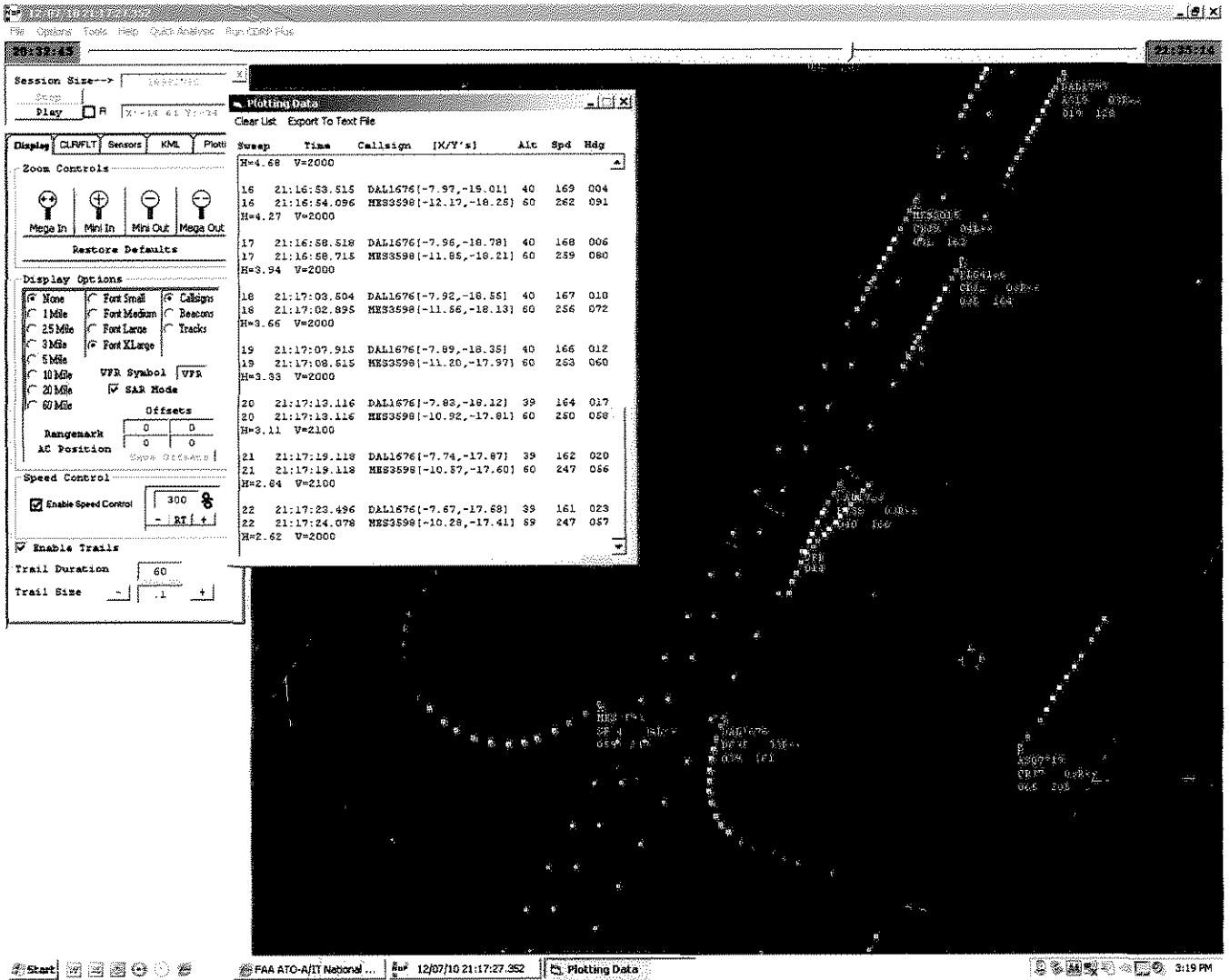
Clear List Export To Text File

Sweep	Time	Callsign	[X/Y/s]	Alt	Spd	Hdg
H=2.27	V=400					
14	21:30:59.701	COM268	[0.61,-2.16]	12	137	029
14	21:30:59.701	FLG4245	[-1.48,-2.97]	17	144	028
H=2.24	V=500					
15	21:31:04.092	COM268	[0.69,-2.01]	12	136	029
15	21:31:04.092	FLG4245	[-1.41,-2.82]	16	142	027
H=2.25	V=400					
16	21:31:09.691	COM268	[0.79,-1.83]	11	135	029
16	21:31:09.692	FLG4245	[-1.32,-2.65]	16	139	028
H=2.25	V=500					
17	21:31:14.493	COM268	[0.87,-1.68]	11	134	028
17	21:31:14.293	FLG4245	[-1.23,-2.48]	15	136	028
H=2.25	V=400					
18	21:31:18.701	COM268	[0.95,-1.54]	10	134	028
18	21:31:18.897	FLG4245	[-1.15,-2.24]	15	134	029
H=2.24	V=500					
19	21:31:23.913	COM268	[1.04,-1.37]	9	133	029
19	21:31:24.111	FLG4245	[-1.05,-2.17]	14	134	030
H=2.24	V=500					
20	21:31:29.112	COM268	[1.13,-1.20]	9	133	029
20	21:31:29.492	FLG4245	[-0.96,-2.03]	13	135	030
H=2.25	V=400					





NO POINT w/o TURN.



Session Size: 15962792

Play R X: -34.43 Y: -66.46

Display: CLMPLT Sessions KML Plotting

Zoom Controls: Mega In, Min In, MIn Out, Mega Out

Display Options:

- 1Mhz Fast Small Clipped
- 25Mhz Fast Medium Beacons
- 3Mhz Fast Large Tracks
- 5Mhz Fast XLarge
- 10Mhz VFR Symbol VFR
- 20Mhz SAR Mode
- 30Mhz

Speed Control:

- Enable Speed Control
- 300

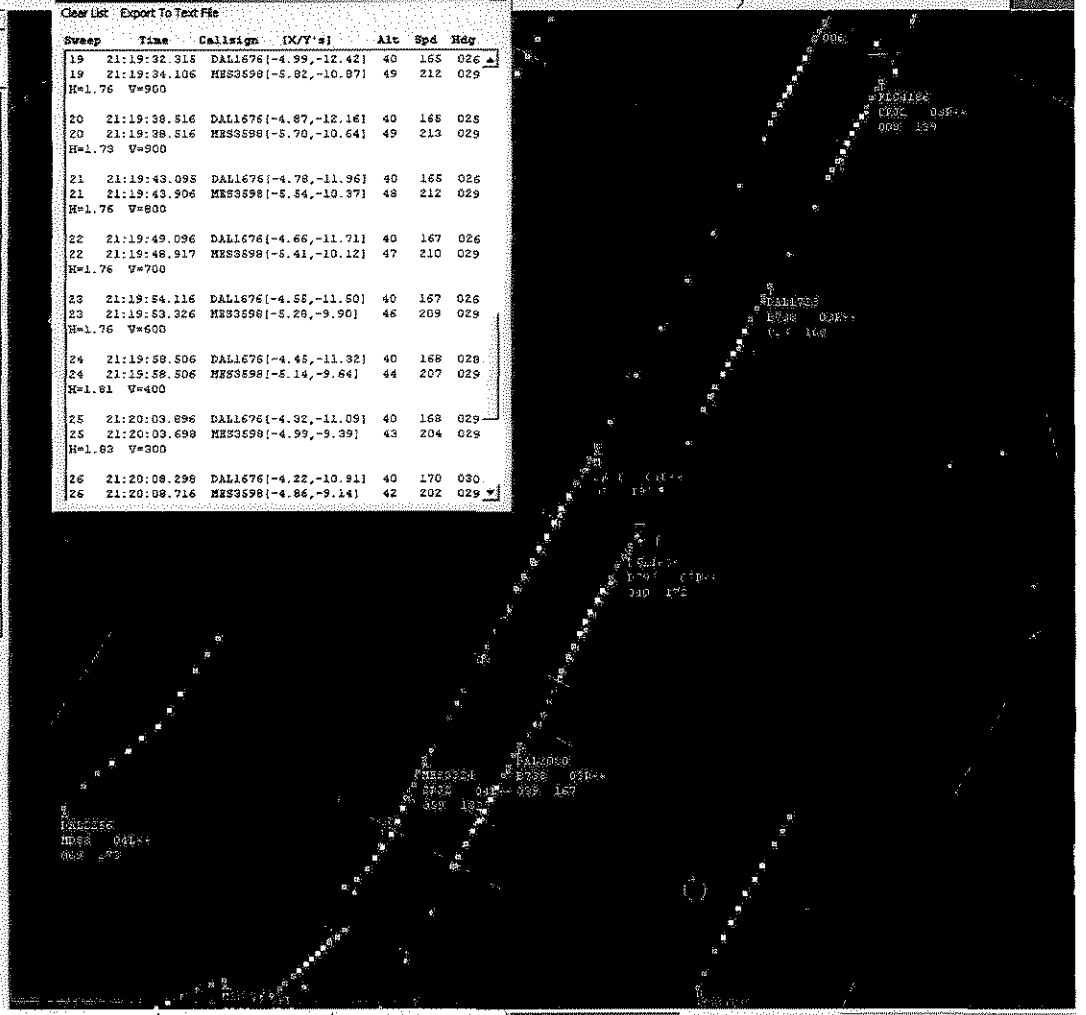
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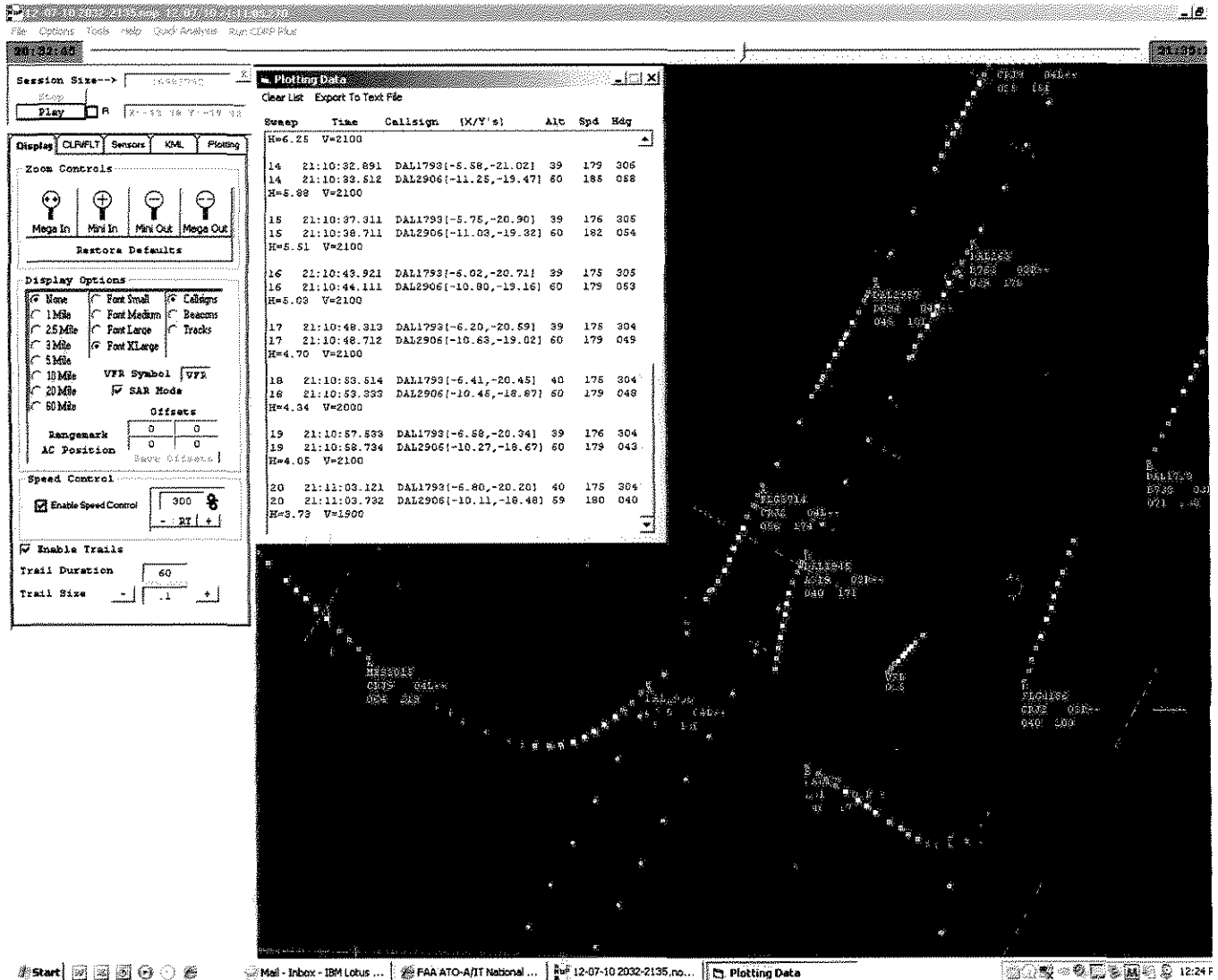
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Plotting Data

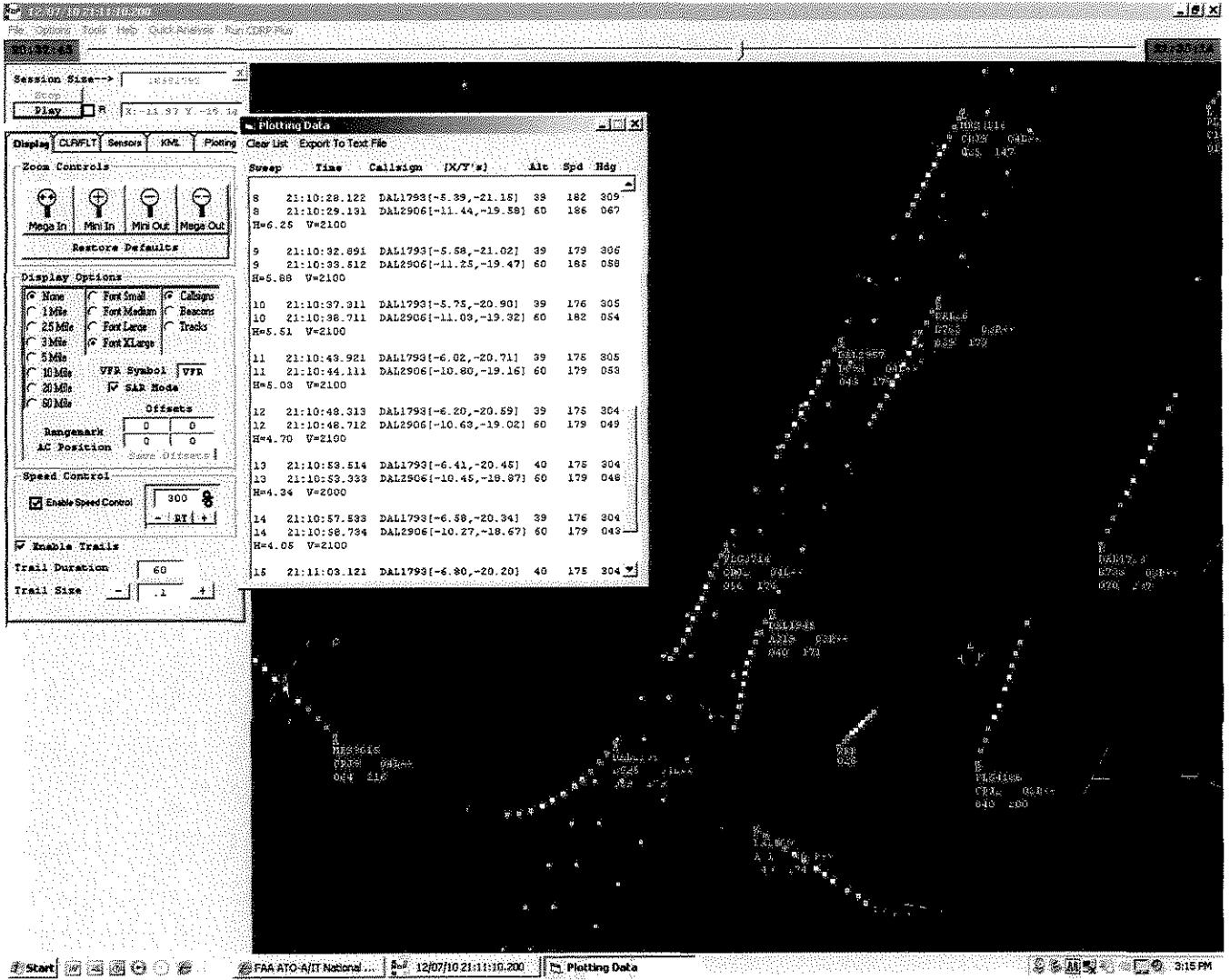
Clear List Export To Text File

Sweep	Time	Call Sign	(X/Y'z)	Alt	Spd	Hdg
19	21:19:32.316	DALL676	(-4.99, -12.42)	40	165	026
19	21:19:34.106	HSS3598	(-5.82, -10.87)	49	212	029
H=1.76 V=900						
20	21:19:38.516	DALL676	(-4.87, -12.16)	40	165	026
20	21:19:38.516	HSS3598	(-5.70, -10.64)	49	213	029
H=1.73 V=900						
21	21:19:43.098	DALL676	(-4.78, -11.96)	40	165	026
21	21:19:43.906	HSS3598	(-5.54, -10.37)	48	212	029
H=1.76 V=800						
22	21:19:49.096	DALL676	(-4.66, -11.71)	40	167	026
22	21:19:48.917	HSS3598	(-5.41, -10.12)	47	210	029
H=1.76 V=700						
23	21:19:54.116	DALL676	(-4.58, -11.50)	40	167	026
23	21:19:53.326	HSS3598	(-5.28, -9.90)	46	209	029
H=1.76 V=600						
24	21:19:59.506	DALL676	(-4.45, -11.32)	40	168	026
24	21:19:58.506	HSS3598	(-5.14, -9.64)	44	207	029
H=1.61 V=400						
25	21:20:03.896	DALL676	(-4.32, -11.09)	40	168	029
25	21:20:03.698	HSS3598	(-4.99, -9.39)	43	204	029
H=1.63 V=300						
26	21:20:09.296	DALL676	(-4.22, -10.91)	40	170	030
26	21:20:09.716	HSS3598	(-4.86, -9.14)	42	202	029





IF YOU GO FURTHER
 AND SAY THAT A 6°
 TURN IS STRAIGHT
 FLIGHT, @ FASTEST
 SPEED IF 182 KTS =
 0.76 NM



Plotting Data

Clear List Export To Text File

Sweep	Time	CallSign	[X/Y's]	Alt	Spd	Hdg
H=1.51 V=300						
55	21:16:34.297	DAL1793	[-1.50,-6.02]	26	168	029
55	21:16:34.115	DAL2906	[-2.57,-4.95]	23	165	029
H=1.51 V=300						
56	21:16:38.314	DAL1793	[-1.42,-5.86]	26	168	028
56	21:16:39.105	DAL2906	[-2.46,-4.75]	22	165	029
H=1.51 V=400						
57	21:16:44.314	DAL1793	[-1.29,-5.61]	24	165	028
57	21:16:44.496	DAL2906	[-2.38,-4.53]	22	164	029
H=1.50 V=200						
58	21:16:49.535	DAL1793	[-1.17,-5.40]	24	164	029
58	21:16:49.715	DAL2906	[-2.23,-4.36]	21	160	029
H=1.50 V=300						
59	21:16:53.935	DAL1793	[-1.08,-5.24]	23	163	029
59	21:16:54.504	DAL2906	[-2.13,-4.17]	20	156	030
H=1.51 V=300						
60	21:16:58.695	DAL1793	[-0.96,-5.05]	22	158	028
60	21:16:59.717	DAL2906	[-2.03,-3.97]	20	154	028
H=1.51 V=200						
61	21:17:04.126	DAL1793	[-0.88,-4.87]	22	161	030
61	21:17:04.126	DAL2906	[-1.96,-3.81]	19	149	028
H=1.51 V=300						

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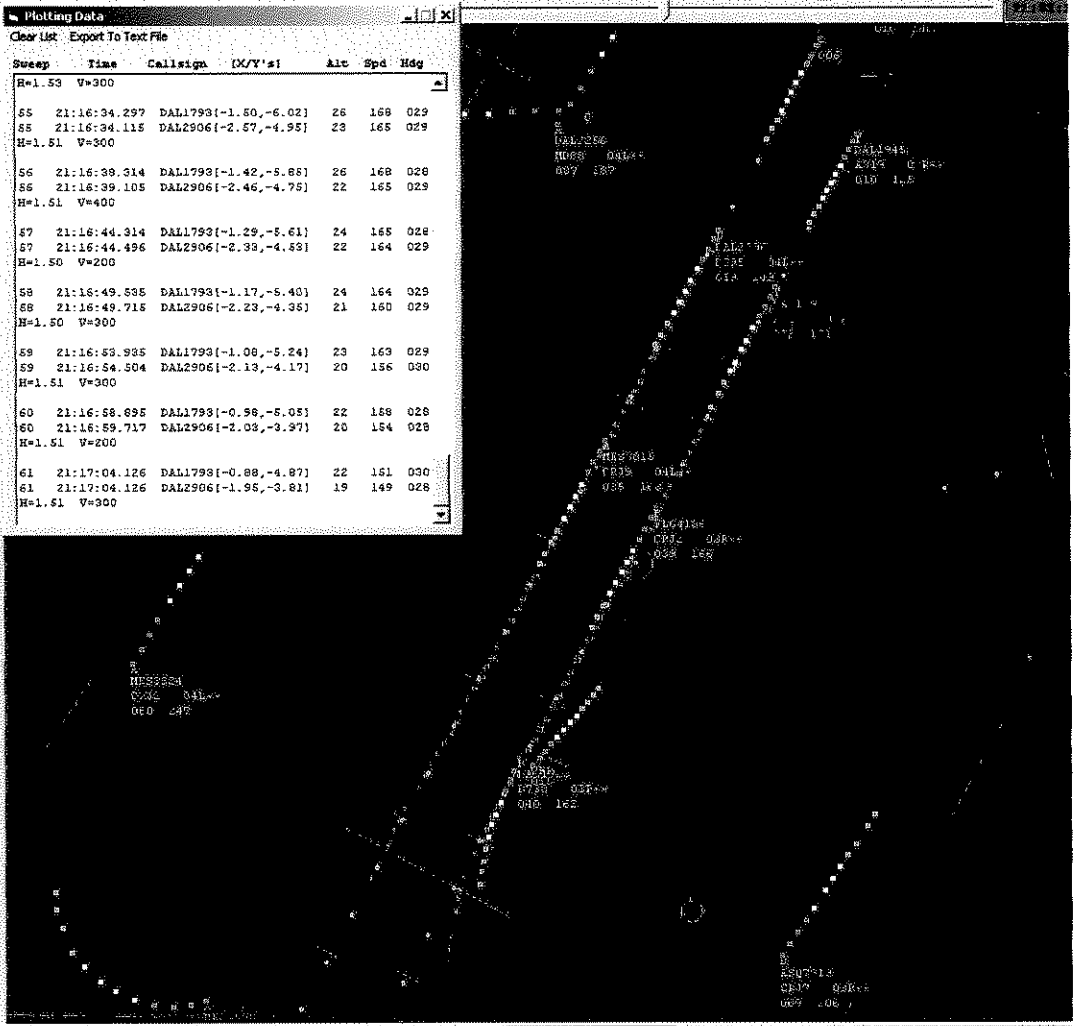
Display: CLPFLT Sensors KML Plotting

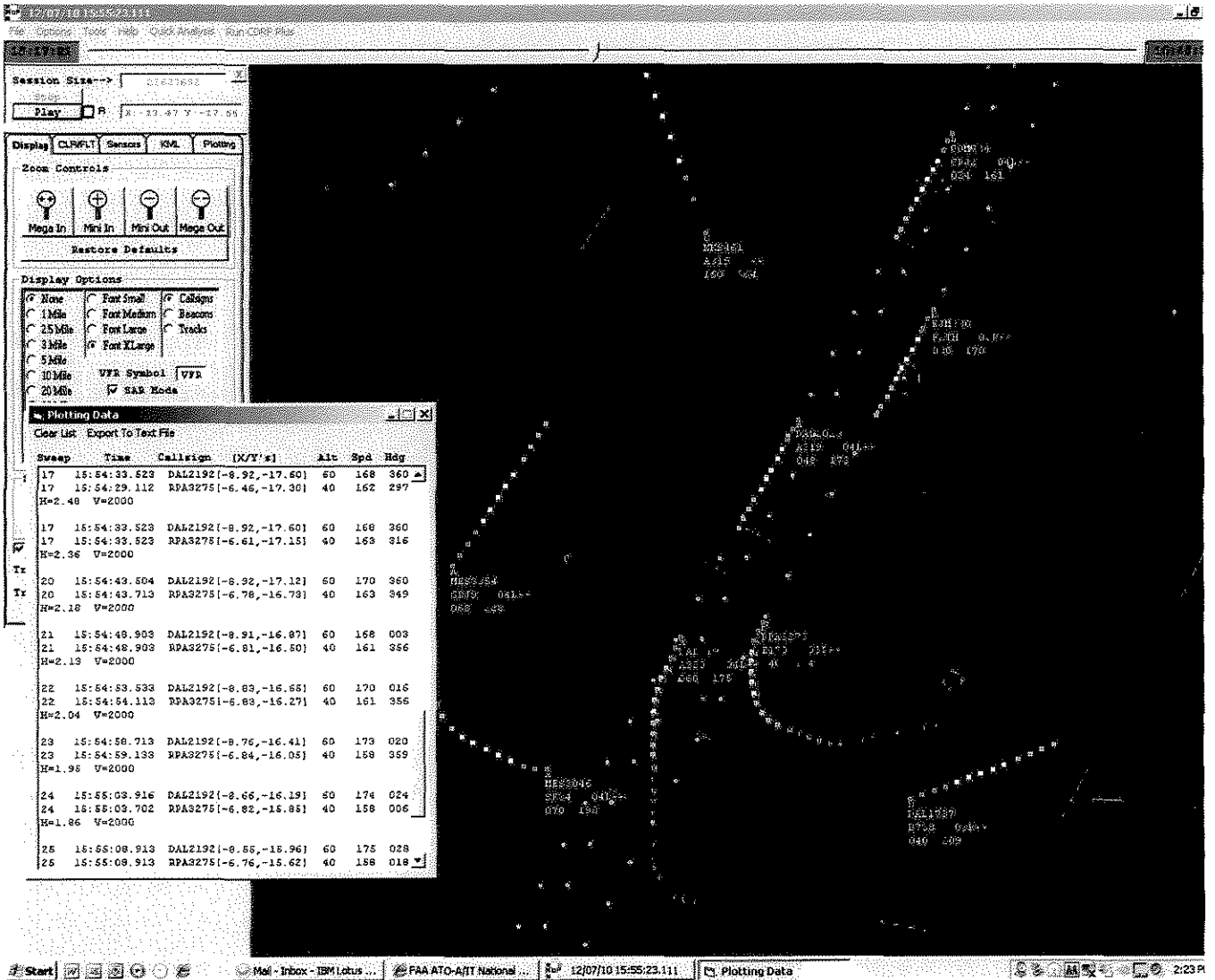
Zoom Controls:
 Mega In Min In Mini Out Mega Out
 Restore Defaults

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 10Mls Font Medium Beacons
 25Mls Font Large Tracks
 3Mls Font XLarge
 5Mls VFR Symbol VFR
 10Mls SAR Mode
 20Mls Offsets
 50Mls
 Rangenmark: 0 0
 AC Position: 0 0
 Data: 411260

Speed Control:
 Enable Speed Control: 300
 - RT +

Enable Trails:
 Enable Trails
 Trail Duration: 60
 Trail Size: - 1 +





I just say what
 A 30 turn is
 straight @ fastest
 speed of 161 kts =
 0.49 nm

12-07-10 1517-1645... Plotting Data

Session Size: 11637692
 Play X=33.27 Y=

Display: CLFLTL Sensors KML F

Zoom Controls:
 Mega In Mini In Mini Out Mega
 Restore Defaults

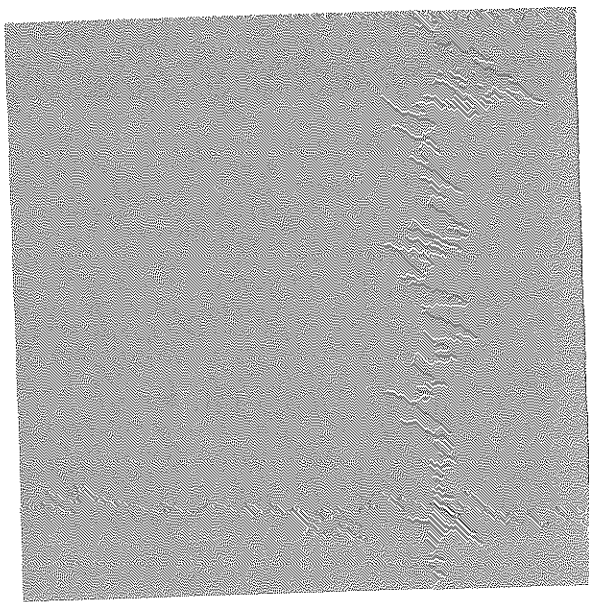
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 None Font Small ColEdge
 1Mile Font Medium Beacon
 25Mile Font Large Tracks
 3Mile Font XLarge
 5Mile
 10Mile VFR Symbol VFR
 20Mile SAR Mode
 50Mile
 Offsets: Range: 0 0 AC Position: 0 0
 Save Offsets

Speed Control:
 Enable Speed Control 300
 - RT +

Enable Trails
 Trail Duration: 60
 Trail Size: .1

Sweep	Time	Call Sign	[X/Y's]	Alt	Spd	Hdg
H=2.36	U=2000					
25	15:54:38.324	DAL219Z	[-8.92, -17.37]	60	169	360
25	15:54:39.113	RPAS275	[-6.73, -16.93]	40	162	336
H=2.23	U=2000					
26	15:54:48.804	DAL219Z	[-8.92, -17.12]	60	170	360
26	15:54:43.713	RPAS275	[-6.78, -16.73]	40	163	349
H=2.18	U=2000					
27	15:54:48.903	DAL219Z	[-8.91, -16.87]	60	168	003
27	15:54:48.903	RPAS275	[-6.81, -16.50]	40	161	366
H=2.13	U=2000					
28	15:54:53.533	DAL219Z	[-8.83, -16.65]	60	170	016
28	15:54:54.113	RPAS275	[-6.83, -16.27]	40	161	366
H=2.04	U=2000					
29	15:54:58.713	DAL219Z	[-8.76, -16.41]	60	173	020
29	15:54:59.133	RPAS275	[-6.84, -16.05]	40	158	359
H=1.95	U=2000					
30	15:55:03.916	DAL219Z	[-8.66, -16.19]	60	174	024
30	15:55:03.702	RPAS275	[-6.82, -15.85]	40	158	006
H=1.86	U=2000					
31	15:55:08.913	DAL219Z	[-8.55, -15.96]	60	175	028
31	15:55:08.913	RPAS275	[-6.76, -15.62]	40	158	018
H=1.82	U=2000					

Taskbar: Start | Mail - Inbox - IBM Lotus ... | FAA ATO-A/IT National ... | C:\Documents and Sett... | 12-07-10 1517-1645.no... | Plotting Data | 11:55



12-07-10
 Session Size: → []
 Stop [] Play [] R X: 18.78 Y: -89.88

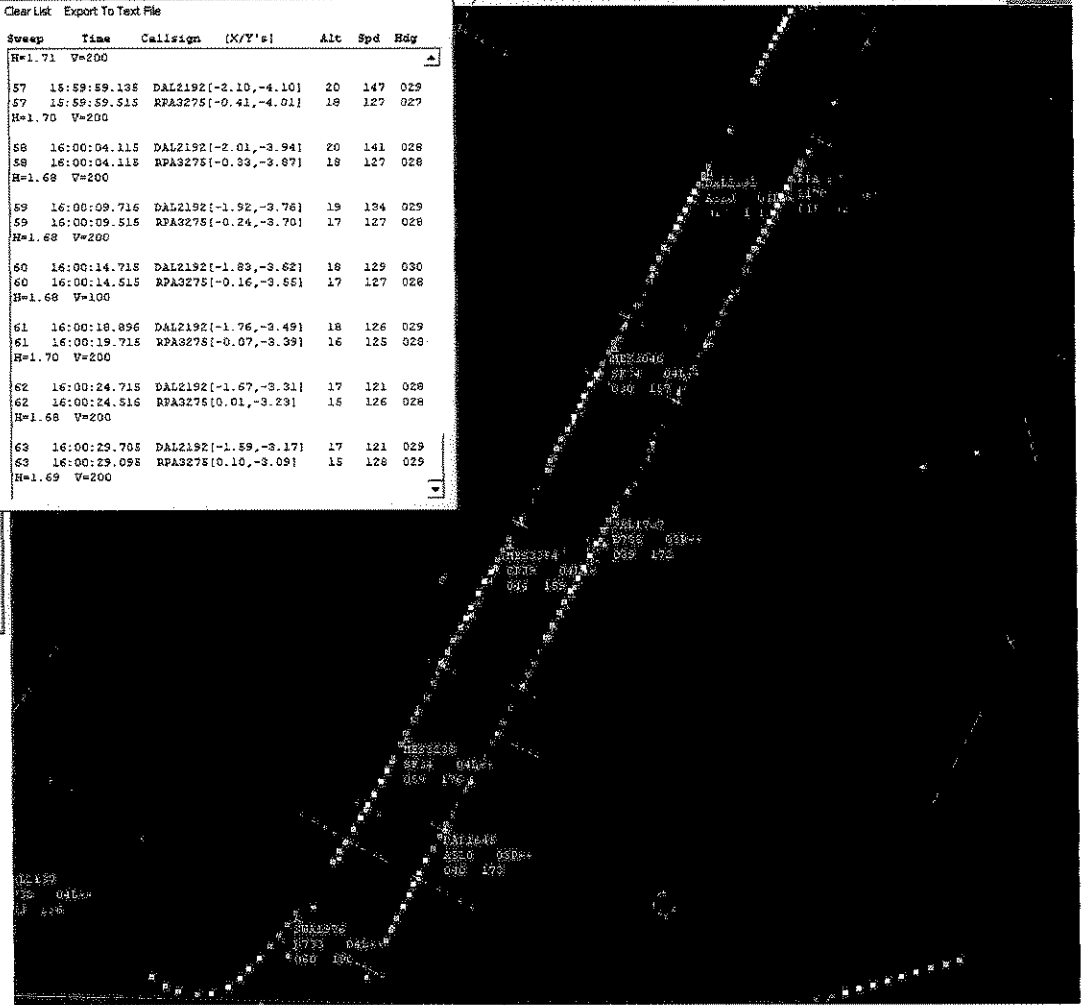
Plotting Data
 Clear List Export To Text File

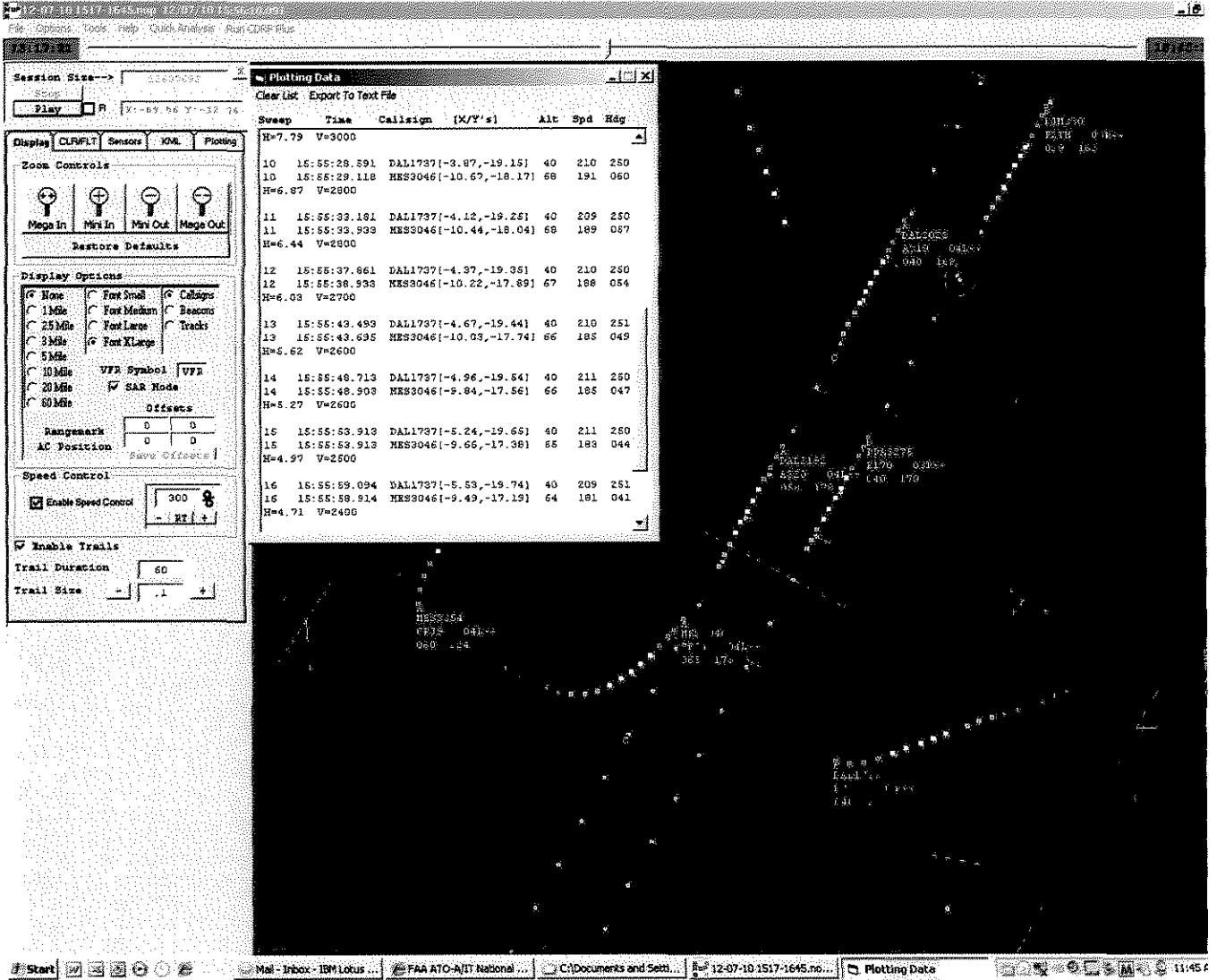
Sweep	Time	CallSign	(X/Y's)	Alt	Spd	Hdg
H=1.71	V=200					
57	16:59:59.135	DAL219Z	(-2.10,-4.101)	20	147	029
57	16:59:59.515	RPA3275	(-0.41,-4.011)	18	127	027
H=1.70	V=200					
58	16:00:04.115	DAL219Z	(-2.01,-3.941)	20	141	028
58	16:00:04.115	RPA3275	(-0.39,-3.871)	18	127	028
H=1.68	V=200					
59	16:00:09.716	DAL219Z	(-1.92,-3.761)	19	134	029
59	16:00:09.515	RPA3275	(-0.24,-3.701)	17	127	028
H=1.68	V=200					
60	16:00:14.715	DAL219Z	(-1.83,-3.621)	18	129	030
60	16:00:14.515	RPA3275	(-0.16,-3.551)	17	127	028
H=1.68	V=100					
61	16:00:18.896	DAL219Z	(-1.76,-3.491)	18	126	029
61	16:00:19.715	RPA3275	(-0.07,-3.391)	16	125	028
H=1.70	V=200					
62	16:00:24.715	DAL219Z	(-1.67,-3.311)	17	121	028
62	16:00:24.516	RPA3275	(0.01,-3.231)	15	126	028
H=1.68	V=200					
63	16:00:29.705	DAL219Z	(-1.59,-3.171)	17	121	029
63	16:00:29.095	RPA3275	(0.10,-3.091)	15	128	029
H=1.69	V=200					

Display: CLRFLT Sensors KML Plotting

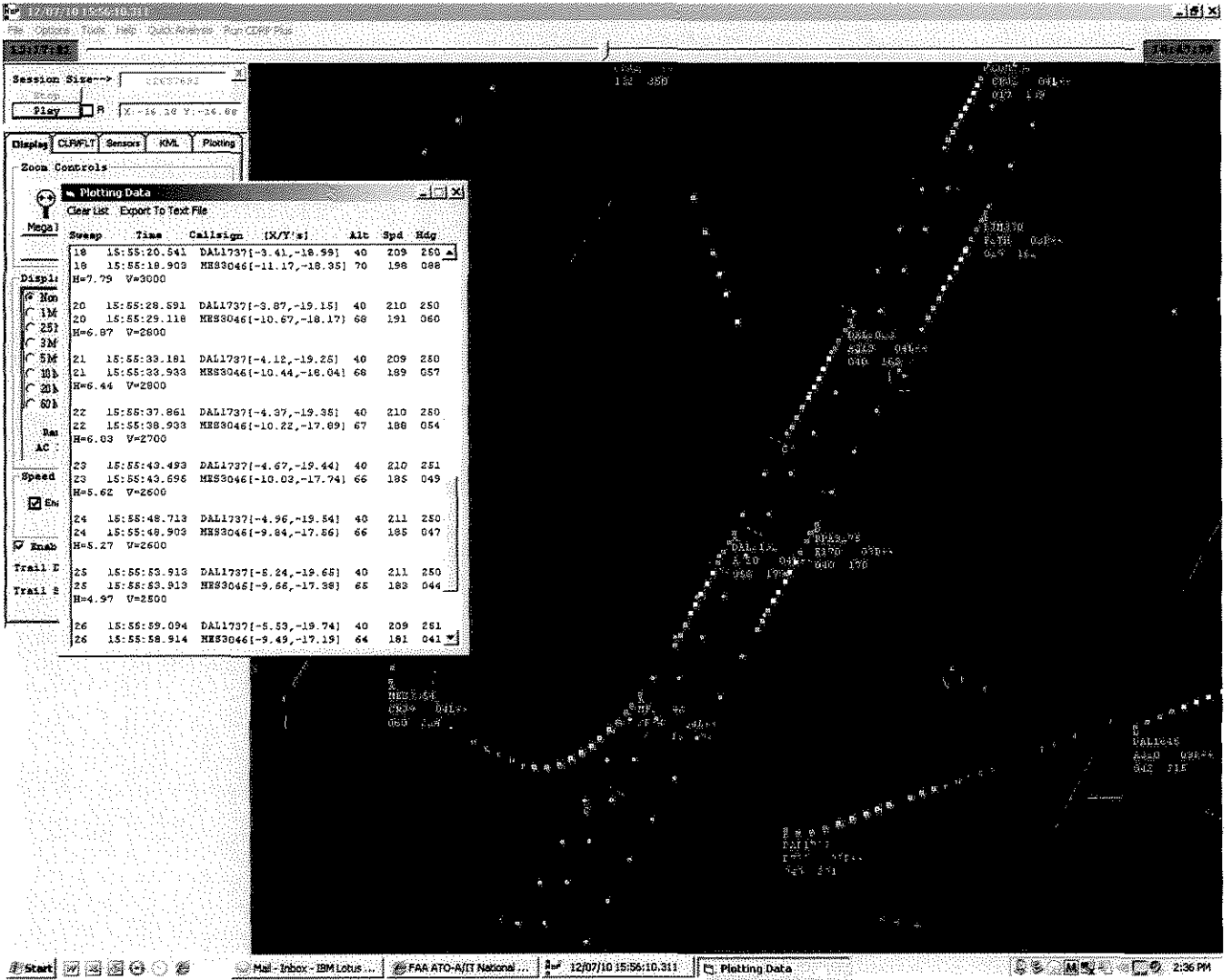
Zoom Controls:
 Mega In Mini In Mini Out Mega Out
 Restore Defaults

Display Options:
 None Font Small CallSigns
 1Mile Font Medium Beacons
 25Mile Font Large Tracks
 3Mile Font XLarge
 5Mile VFR Symbol VFR
 10Mile SAR Mode
 20Mile Offsets
 50Mile
 Rangemark: 0 0
 AC Position: 0 0
 Speed Control: Enable Speed Control 300
 Enable Trails
 Trail Duration: 60
 Trail Size: 1





NO point w/o TURN



Session Size: 2000000
 Play [] [] X-66.39 Y-12.01

Display: CLRF17 Sensors KML Plotting

Zoom Controls:
 Magn In Magn Out
 Restore Defaults

Display Options:
 None Fast Small Calligns
 1MHz Fast Medium Resonance
 25MHz Fast Large Tracks
 3MHz Fast XLarge
 5MHz VFR Symbol VFR
 10MHz SAR Mode
 20MHz SAR Mode
 60MHz Offsets

Range/Mark: 0 0
 AC Position: 0 0

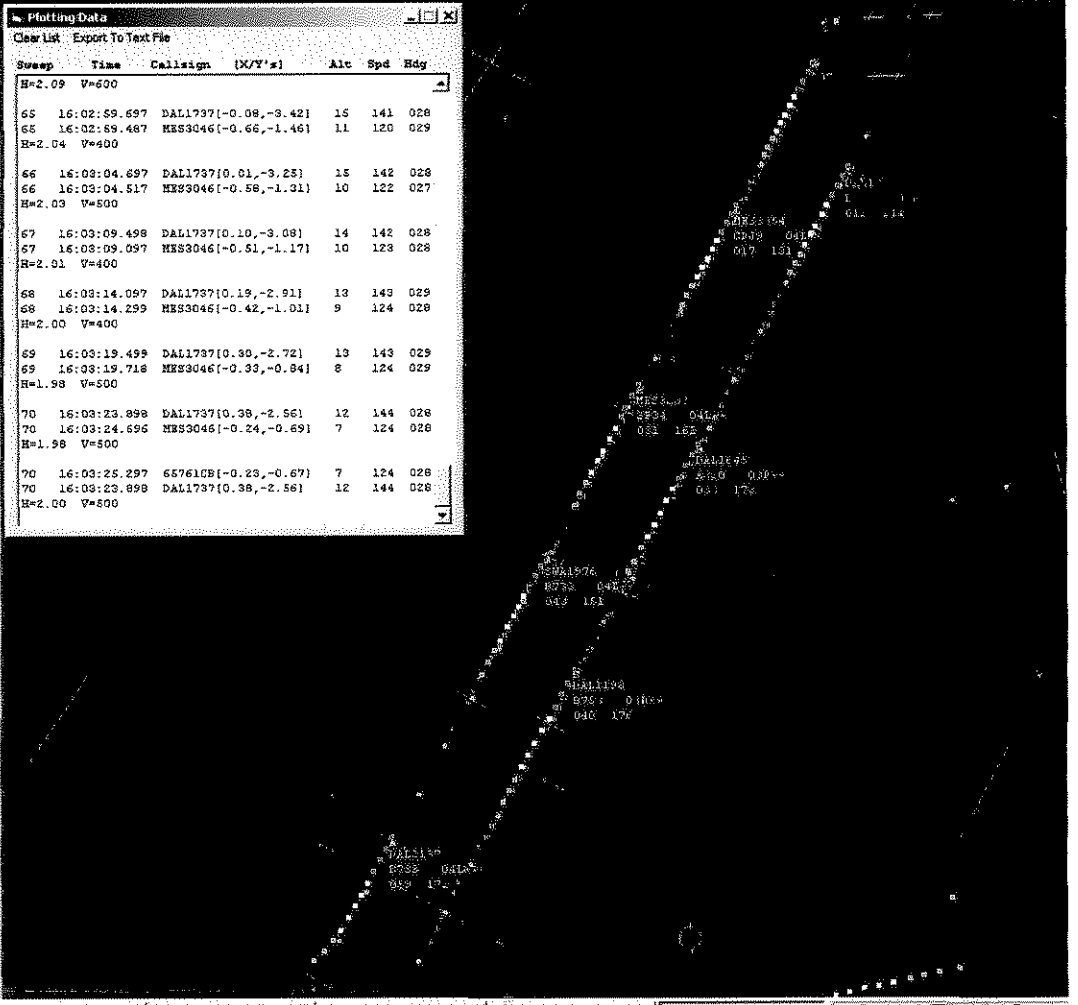
Speed Control:
 Enable Speed Control 300
 - RT +

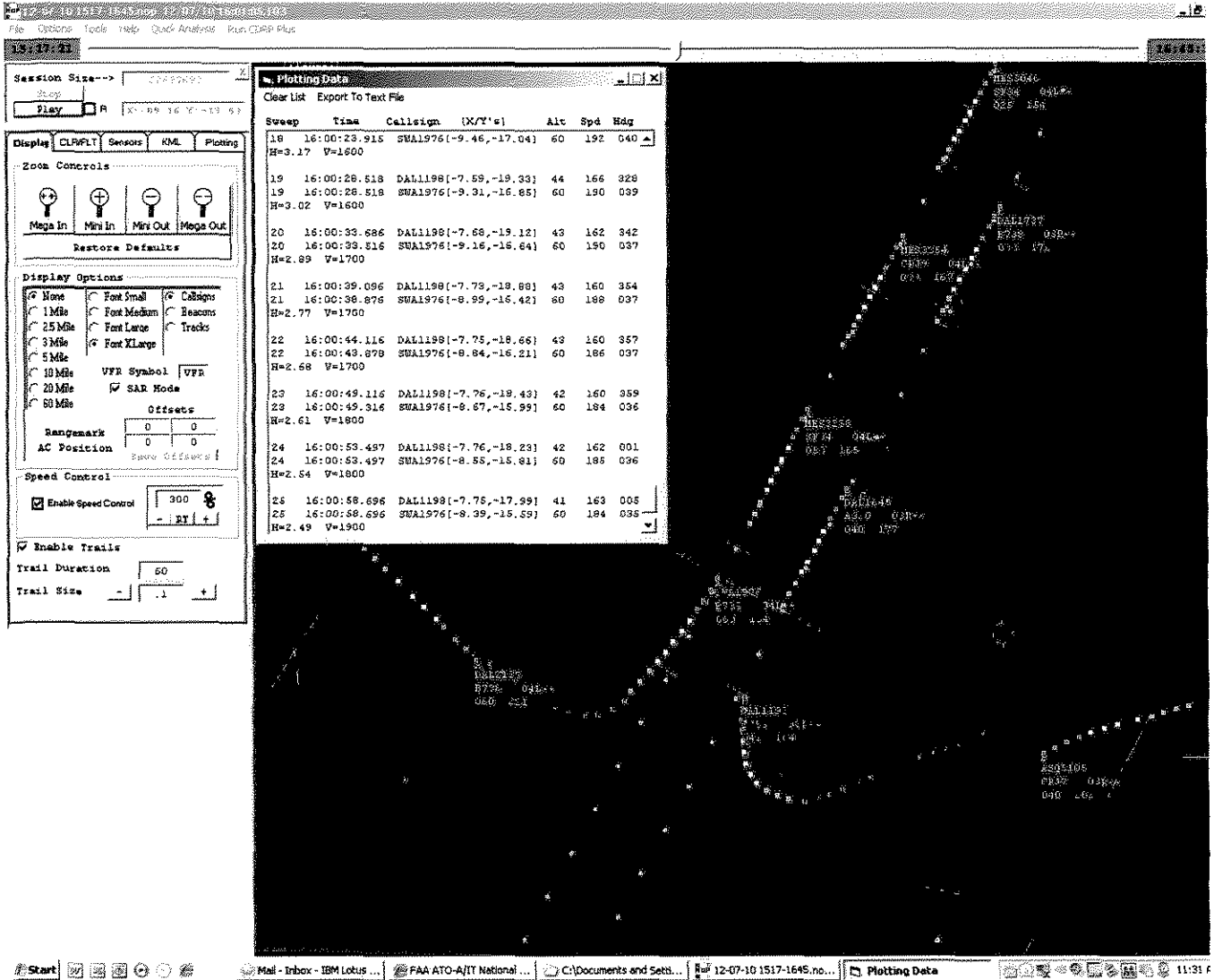
Enable Trails
 Trail Duration: 60
 Trail Size: .1

Plotting Data

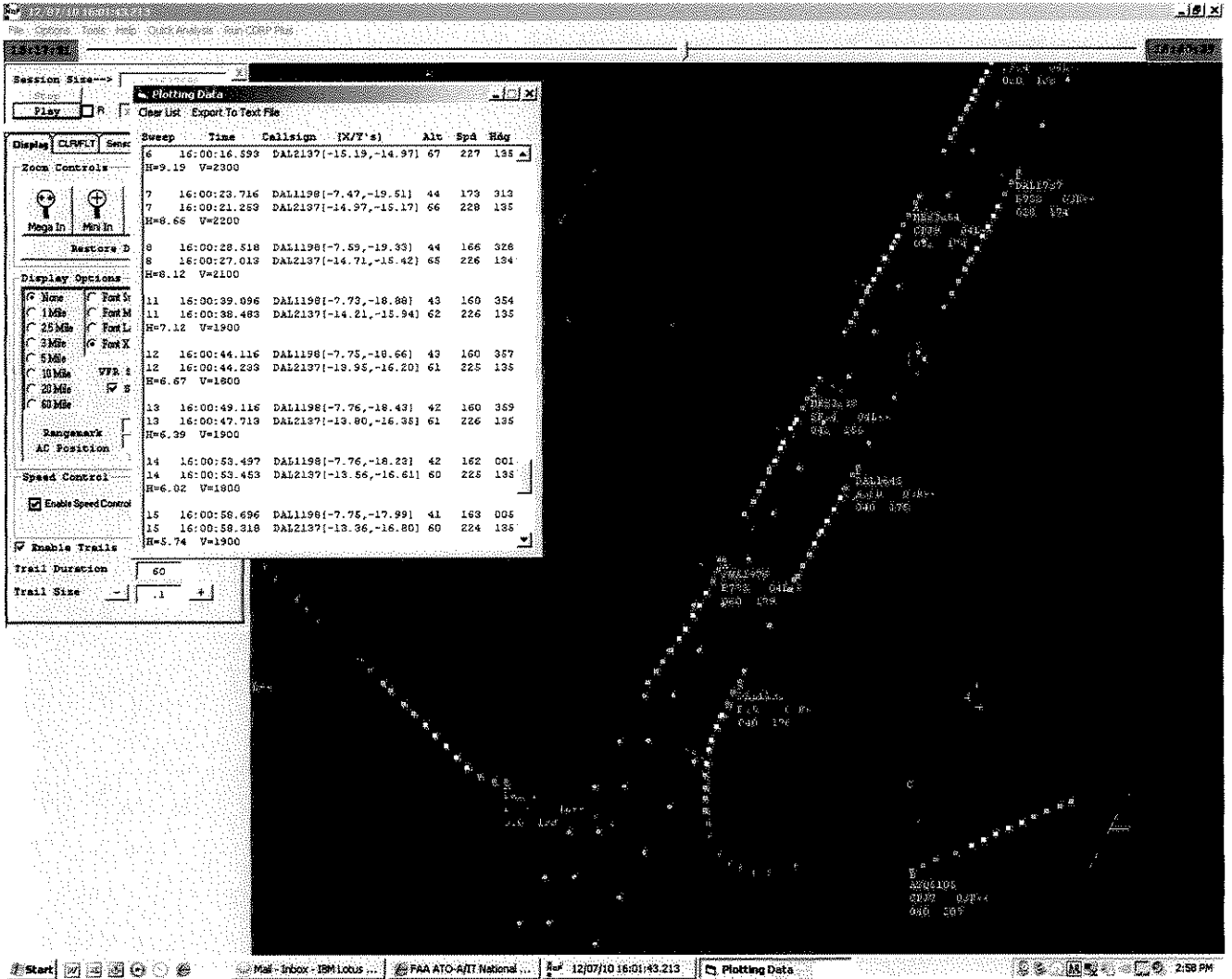
Clear List Export To Text File

Sweep	Time	Callign	[X/Y's]	Alt	Spd	Hdg
H=2.09 V=600						
65	16:02:59.697	DAL1737	[-0.08,-3.42]	15	141	028
65	16:02:59.487	MES3046	[-0.66,-1.46]	11	120	029
H=2.04 V=500						
66	16:03:04.697	DAL1737	[0.01,-3.25]	15	142	028
66	16:03:04.517	MES3046	[-0.58,-1.31]	10	122	027
H=2.03 V=500						
67	16:03:09.498	DAL1737	[0.10,-3.08]	14	142	028
67	16:03:09.097	MES3046	[-0.51,-1.17]	10	128	028
H=2.01 V=400						
68	16:03:14.097	DAL1737	[0.19,-2.91]	13	143	029
68	16:03:14.259	MES3046	[-0.42,-1.01]	9	124	029
H=2.00 V=400						
69	16:03:19.499	DAL1737	[0.30,-2.72]	13	143	029
69	16:03:19.718	MES3046	[-0.33,-0.94]	8	124	029
H=1.98 V=500						
70	16:03:23.898	DAL1737	[0.38,-2.56]	12	144	028
70	16:03:24.696	MES3046	[-0.24,-0.69]	7	124	028
H=1.98 V=500						
70	16:03:25.297	65761GB	[-0.23,-0.67]	7	124	028
70	16:03:23.898	DAL1737	[0.38,-2.56]	12	144	028
H=2.00 V=800						





IF you CLAIM THAT
 A 70 TURN IS
 STRAIGHT FLIGHT
 (354-001) @
 THE FASTEST SPEED OF
 162 KTS =
 0.68 NM



Session Size: 21637892
 Scope: R X-11.24 Y-07.19
 Play

Display: CLFLY Sensors KML Plotting

Zoom Controls:
 Mega In Mini In Mini Out Mega Out
 Restore Defaults

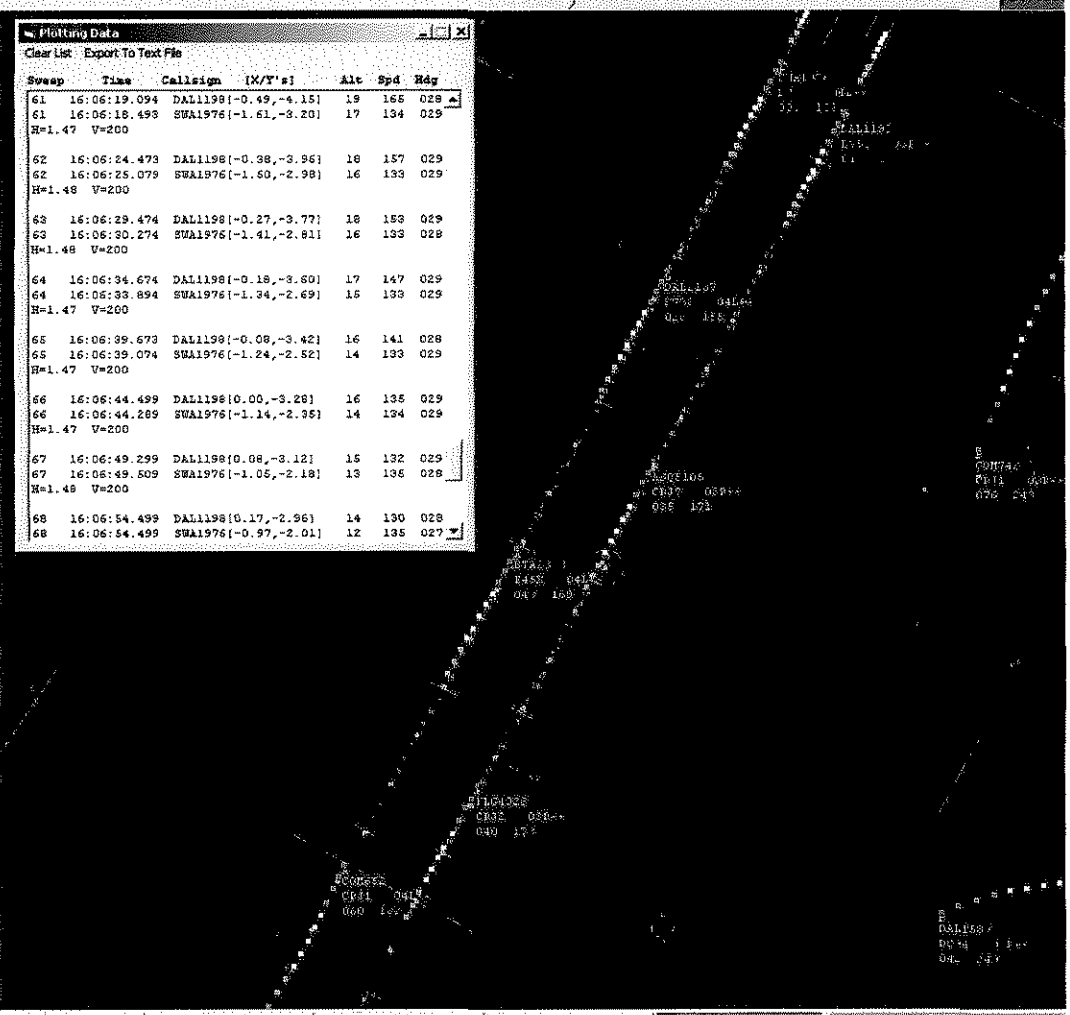
Display Options:
 None Font Small Callsign
 1Mhz Font Medium Seasons
 25Mhz Font Large Tracks
 3Mhz Font XLarge
 5Mhz VFR Symbol VFR
 10Mhz SAR Mode
 20Mhz
 60Mhz
 Offsets: [0] [0]
 Rangesmark: [0] [0]
 AC Position: [0] [0]
 Save Offsets

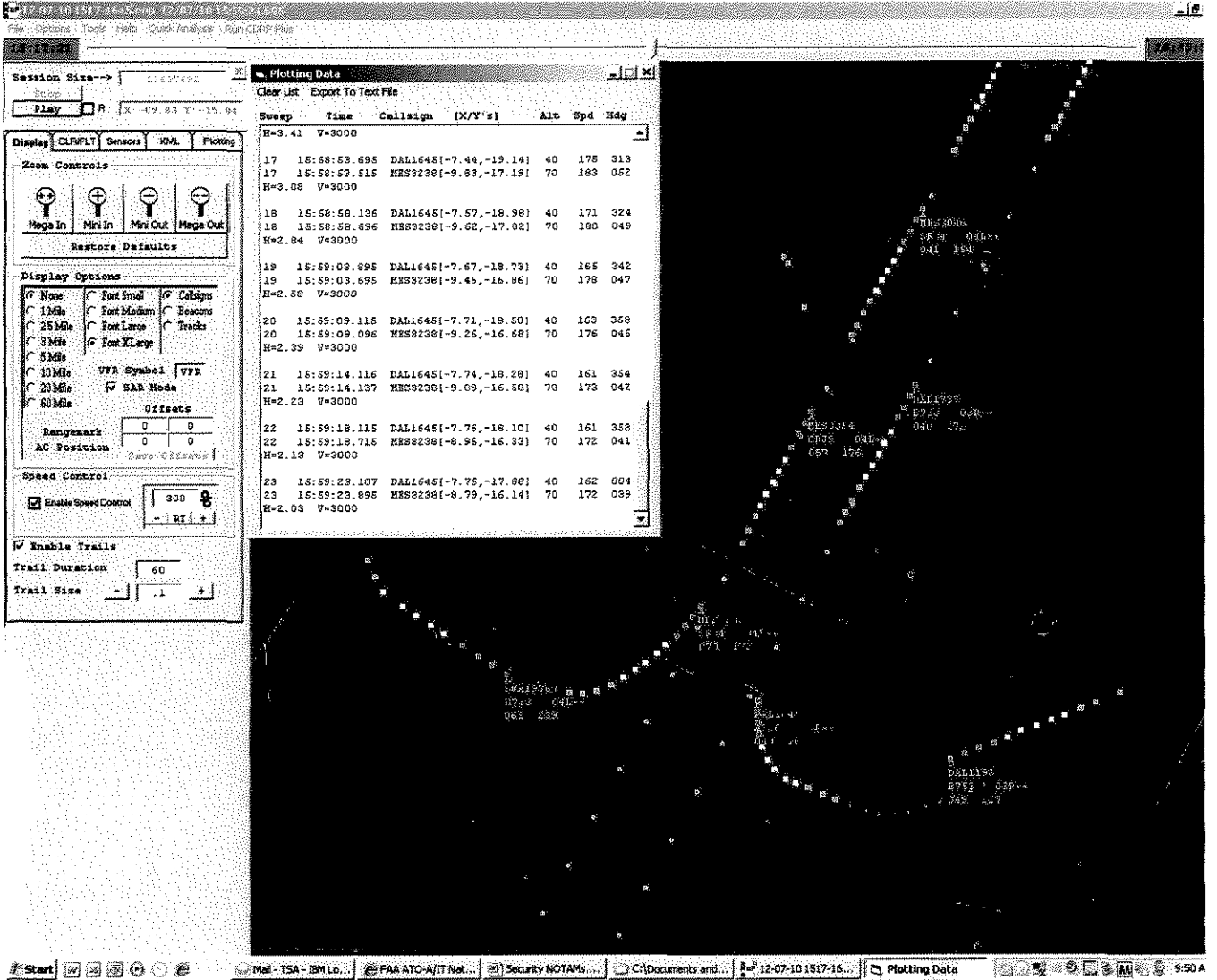
Speed Control:
 Enable Speed Control [300]
 - RT +

Enable Trails
 Trail Duration: [60]
 Trail Size: [-] .1 [+]

Plotting Data
 Clear List Export To Text File

Swap	Time	Callsign	[X/Y/z]	Alt	Spd	Hdg
61	16:06:19.094	DAL1198	[-0.49,-4.15]	19	165	028
61	16:06:18.493	SWA1976	[-1.61,-3.20]	17	134	029
H=1.47 V=200						
62	16:06:24.473	DAL1198	[-0.38,-3.96]	18	157	029
62	16:06:23.079	SWA1976	[-1.50,-2.98]	16	133	029
H=1.48 V=200						
63	16:06:29.474	DAL1198	[-0.27,-3.77]	18	153	029
63	16:06:30.274	SWA1976	[-1.41,-2.81]	16	133	028
H=1.48 V=200						
64	16:06:34.674	DAL1198	[-0.18,-3.60]	17	147	029
64	16:06:33.894	SWA1976	[-1.34,-2.69]	15	133	029
H=1.47 V=200						
65	16:06:39.673	DAL1198	[-0.08,-3.42]	16	141	028
65	16:06:39.074	SWA1976	[-1.24,-2.52]	14	133	029
H=1.47 V=200						
66	16:06:44.499	DAL1198	[0.00,-3.28]	16	135	029
66	16:06:44.289	SWA1976	[-1.14,-2.35]	14	134	029
H=1.47 V=200						
67	16:06:49.299	DAL1198	[0.08,-3.12]	15	132	029
67	16:06:49.509	SWA1976	[-1.05,-2.18]	13	136	028
H=1.48 V=200						
68	16:06:54.499	DAL1198	[0.17,-2.96]	14	130	028
68	16:06:54.499	SWA1976	[-0.97,-2.01]	12	135	027





353° - 358° straight?

= 0.41
STRAIGHT.

12/07/10 15:59:59.883

File Options Tools Help Quick Analysis Run CDRP File

Session Size: 2007452

Play [] [X:13.48 Y:16.43]

Display: CLP/FLT Sensors KML Plotting

Zoom Controls

Plotting Data

Clear List Export To Text File

Best	Sweep	Time	Callsign	[X/Y's]	Alt	Spd	Hdg
H=2.03 V=3000							
20	16:59:28.715	DALL645	[-7.70,-17.62]	40	164	013	
20	16:59:29.108	NHS3238	[-8.64,-15.94]	70	170	036	
H=1.93 V=3000							
21	16:59:33.695	DALL645	[-7.64,-17.39]	40	165	019	
21	16:59:34.715	NHS3238	[-8.49,-15.72]	69	172	035	
H=1.07 V=2900							
22	16:59:39.296	DALL645	[-7.53,-17.15]	40	166	024	
22	16:59:39.115	NHS3238	[-8.37,-15.53]	69	174	032	
H=1.02 V=2900							
23	16:59:43.896	DALL645	[-7.44,-16.95]	40	168	027	
23	16:59:43.495	NHS3238	[-8.24,-15.36]	68	175	034	
H=1.78 V=2800							
24	16:59:48.896	DALL645	[-7.33,-16.74]	40	169	029	
24	16:59:48.695	NHS3238	[-8.11,-15.14]	68	176	033	
H=1.78 V=2800							
25	16:59:54.115	DALL645	[-7.23,-16.53]	40	168	027	
25	16:59:53.696	NHS3238	[-7.98,-14.93]	67	176	032	
H=1.77 V=2700							
26	16:59:59.135	DALL645	[-7.12,-16.31]	40	169	027	
26	16:59:59.135	NHS3238	[-7.85,-14.70]	66	176	031	
H=1.77 V=2600							

Display Opt: None, 1Mile, 25Mile, 3Mile, 5Mile, 10Mile, 20Mile, 50Mile

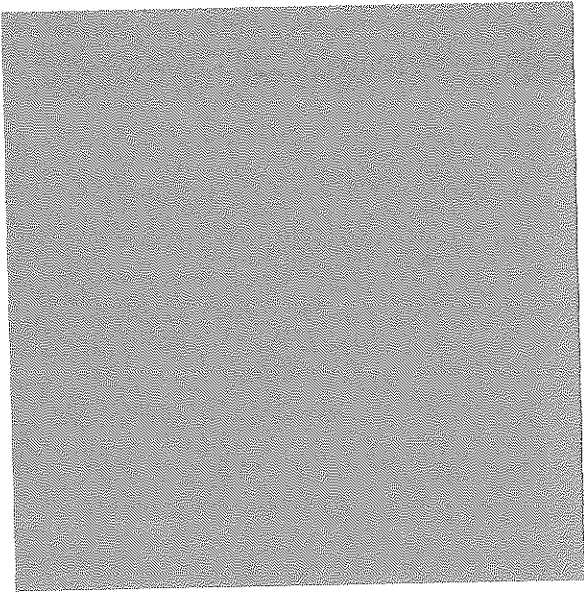
Range: AC Vertical

Speed Contr: Enable Spd

Enable Trs

Trail Durat: Trail Size

Taskbar: Start Mail - Inbox - IBM Lotus ... FAA ATC-A/IT National ... 12/07/10 15:59:59.883 Plotting Data 2:40 PM



Session Size--> 2143952

Play R X: -88.83 Y: -35.47

Display CLMFL Sensors KML Plotting

Room Controls

MegaIn MiniIn MiniOut MegaOut

Restore Defaults

Display Options

None Font Small Columns

1Mile Font Medium Resonance

25Mile Font Large Tracks

5Mile Font XLarge

10Mile VFR Symbol VFR

20Mile SAZ Mode

50Mile

Offsets

RangeMark 0 0

AC Position 0 0

Speed Control

Enable Speed Control 300

Enable Trails

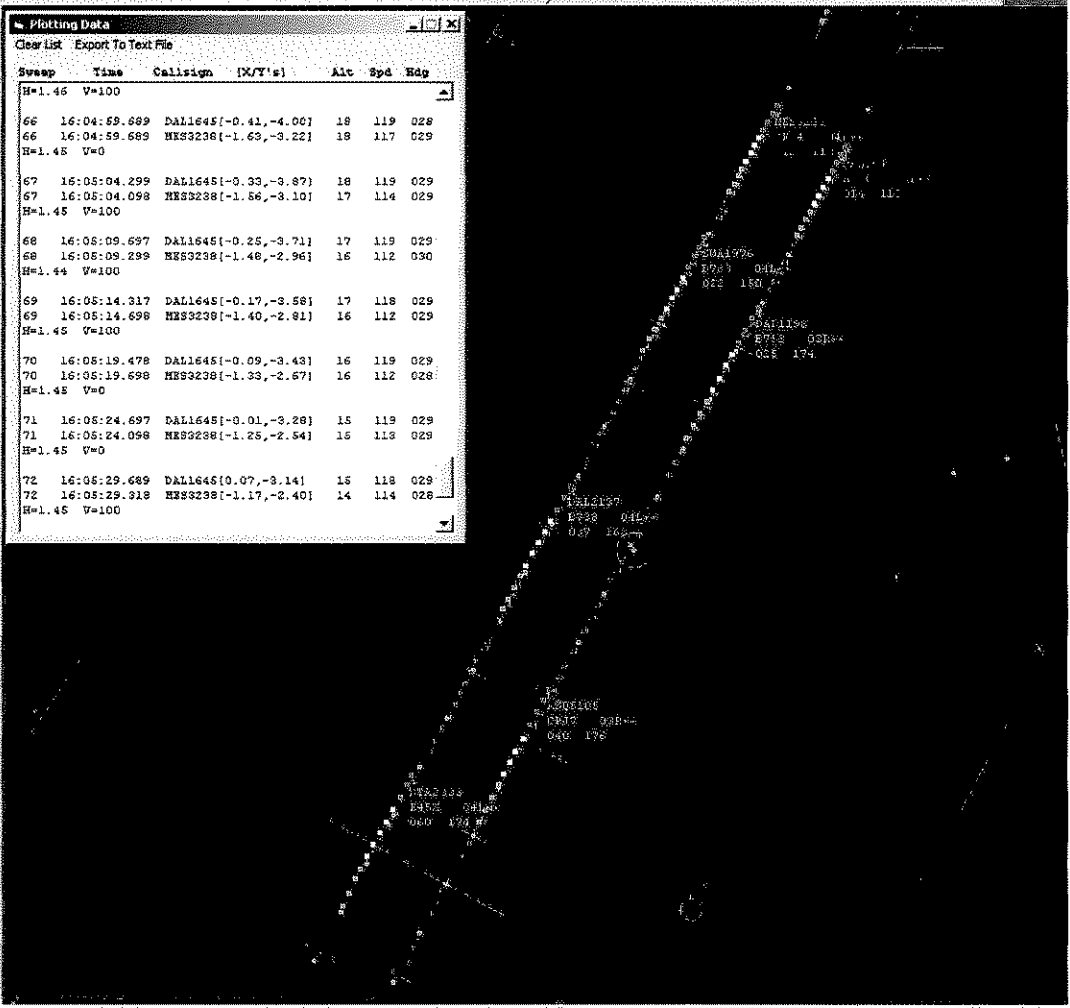
Trail Duration 60

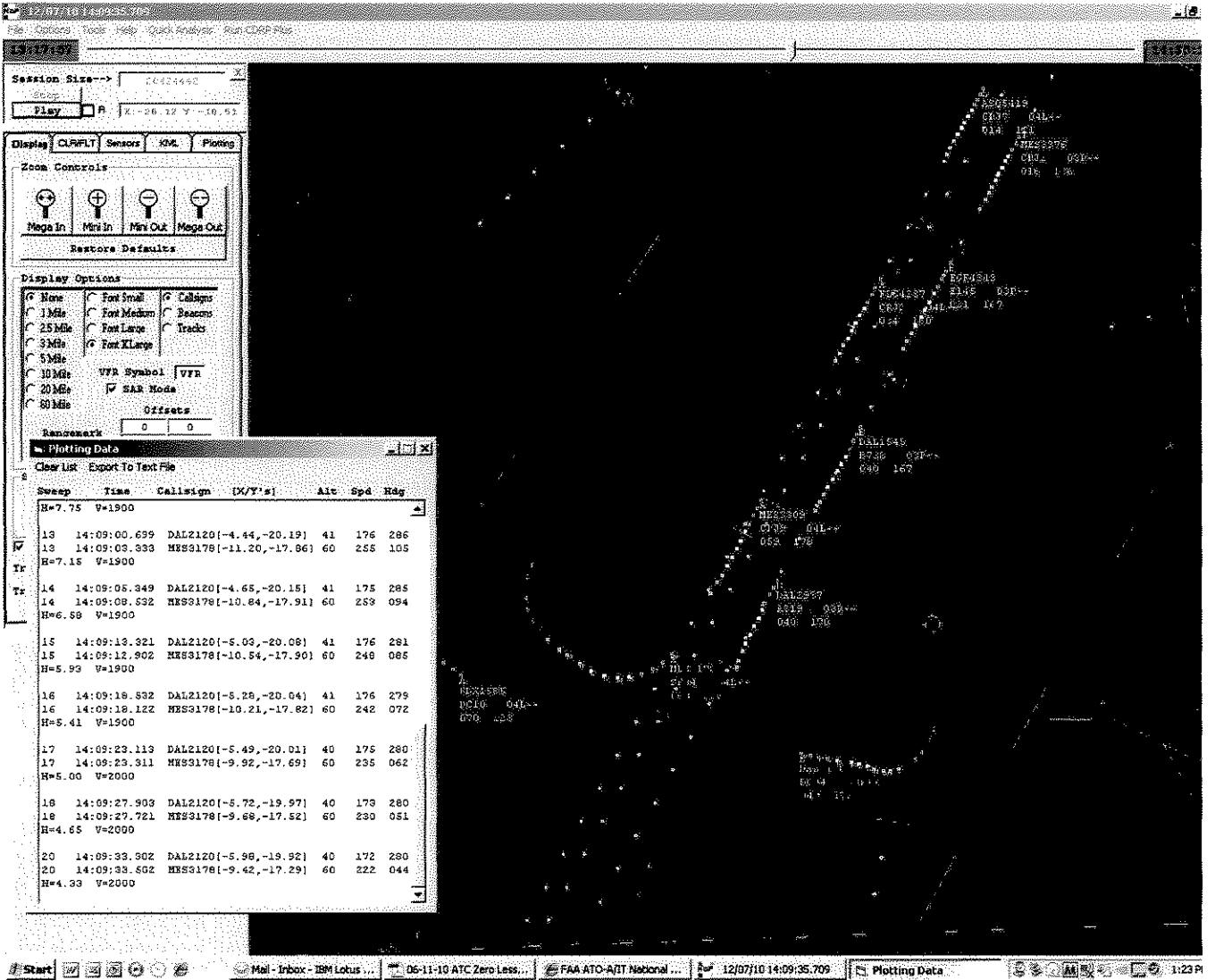
Trail Size .1

Plotting Data

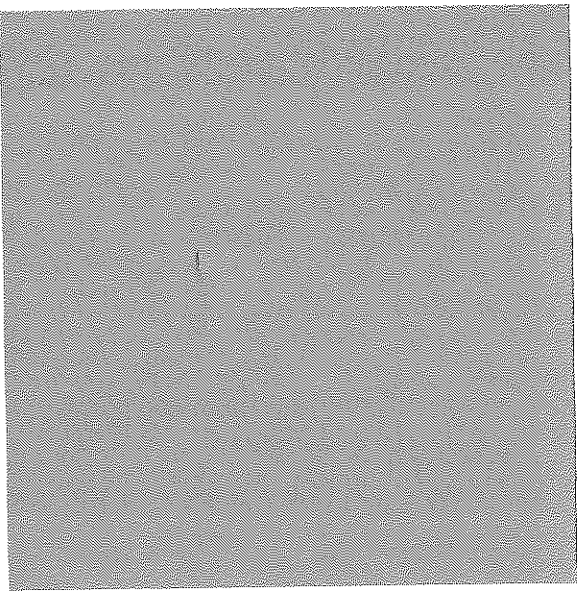
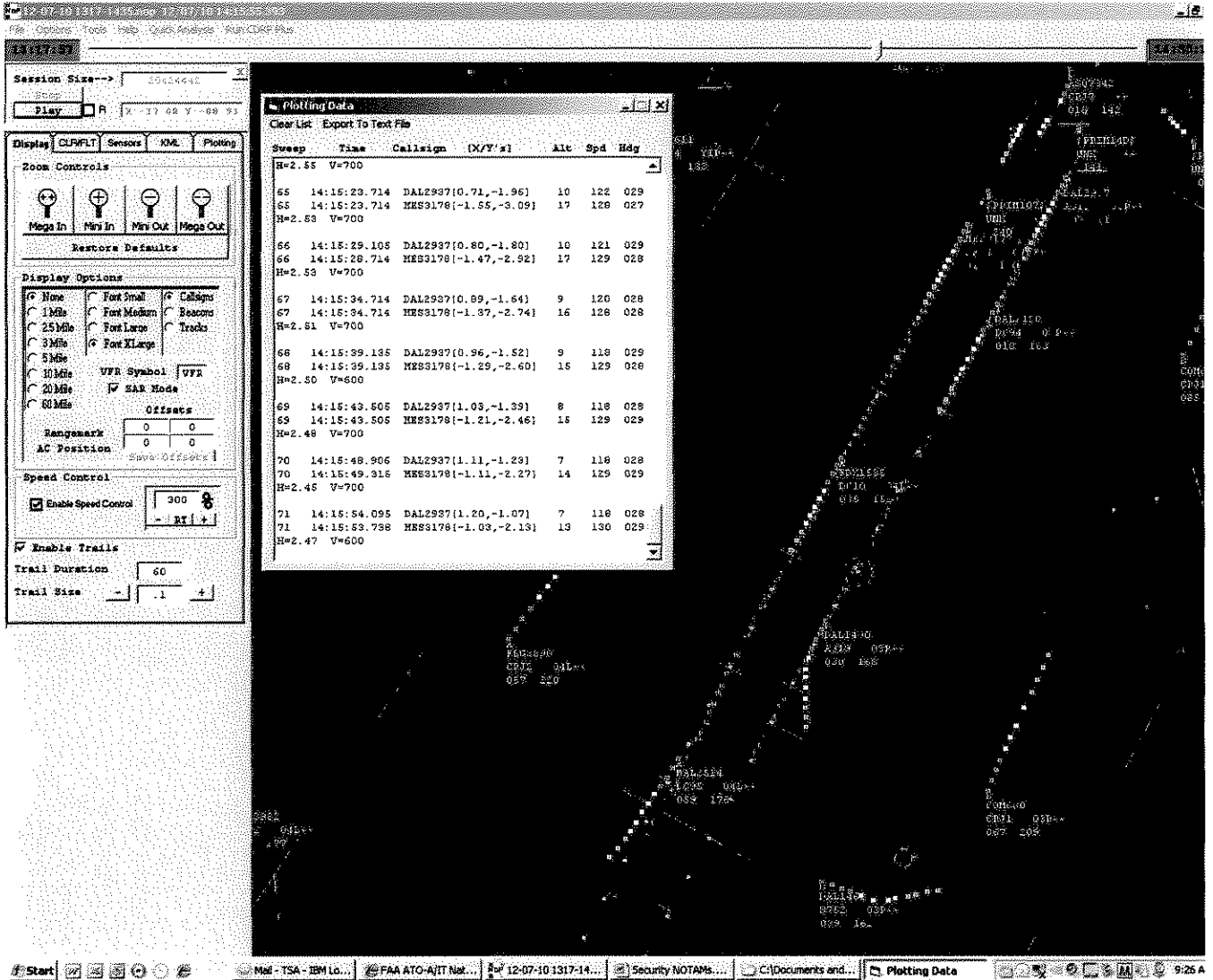
Clear List Export to Text File

Sweep	Time	CallSign	[X,Y]'s	Alt	Spd	Hdg
H=1.46	V=100					
66	16:04:59.689	DALL645	[-0.41,-4.06]	18	119	028
66	16:04:59.689	HNS3238	[-1.63,-3.22]	18	117	029
H=1.48	V=0					
67	16:05:04.299	DALL645	[-0.33,-3.87]	18	119	029
67	16:05:04.098	HNS3238	[-1.56,-3.10]	17	114	029
H=1.45	V=100					
68	16:05:09.697	DALL645	[-0.25,-3.71]	17	119	029
68	16:05:09.299	HNS3238	[-1.46,-2.96]	16	112	030
H=1.44	V=100					
69	16:05:14.317	DALL645	[-0.17,-3.58]	17	118	029
69	16:05:14.698	HNS3238	[-1.40,-2.81]	16	112	029
H=1.45	V=100					
70	16:05:19.478	DALL645	[-0.09,-3.43]	16	119	029
70	16:05:19.698	HNS3238	[-1.33,-2.67]	16	112	028
H=1.45	V=0					
71	16:05:24.697	DALL645	[-0.01,-3.28]	15	119	029
71	16:05:24.098	HNS3238	[-1.25,-2.54]	15	113	029
H=1.45	V=0					
72	16:05:29.689	DALL645	[0.07,-3.14]	15	118	029
72	16:05:29.318	HNS3238	[-1.17,-2.40]	14	114	028
H=1.45	V=100					





NO POINT W/O TURN



Session Size--> 21623440
 Play X: 11.04 Y: 07.60

Display CLRF1 Sensors KM Plotting

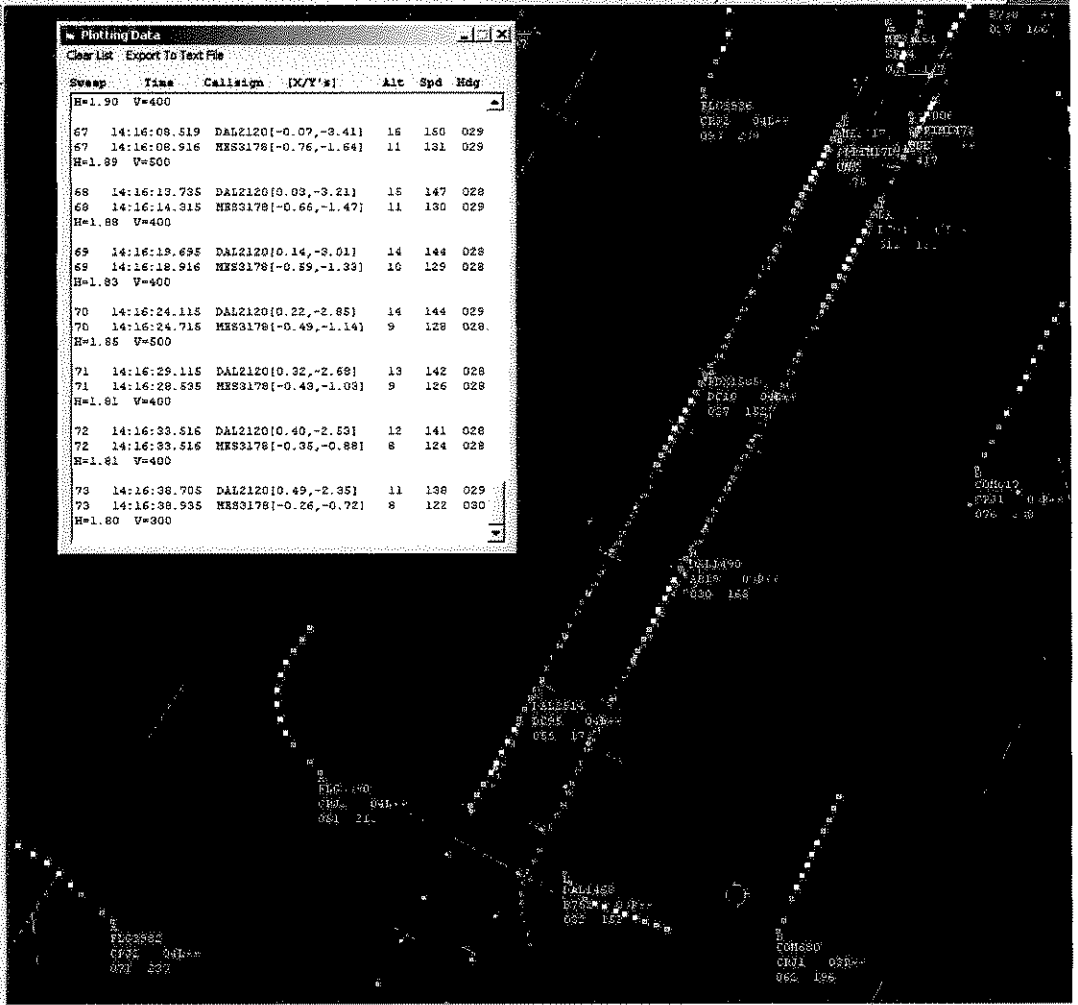
Zoom Controls
 Mega In Mega Out
 Restore Defaults

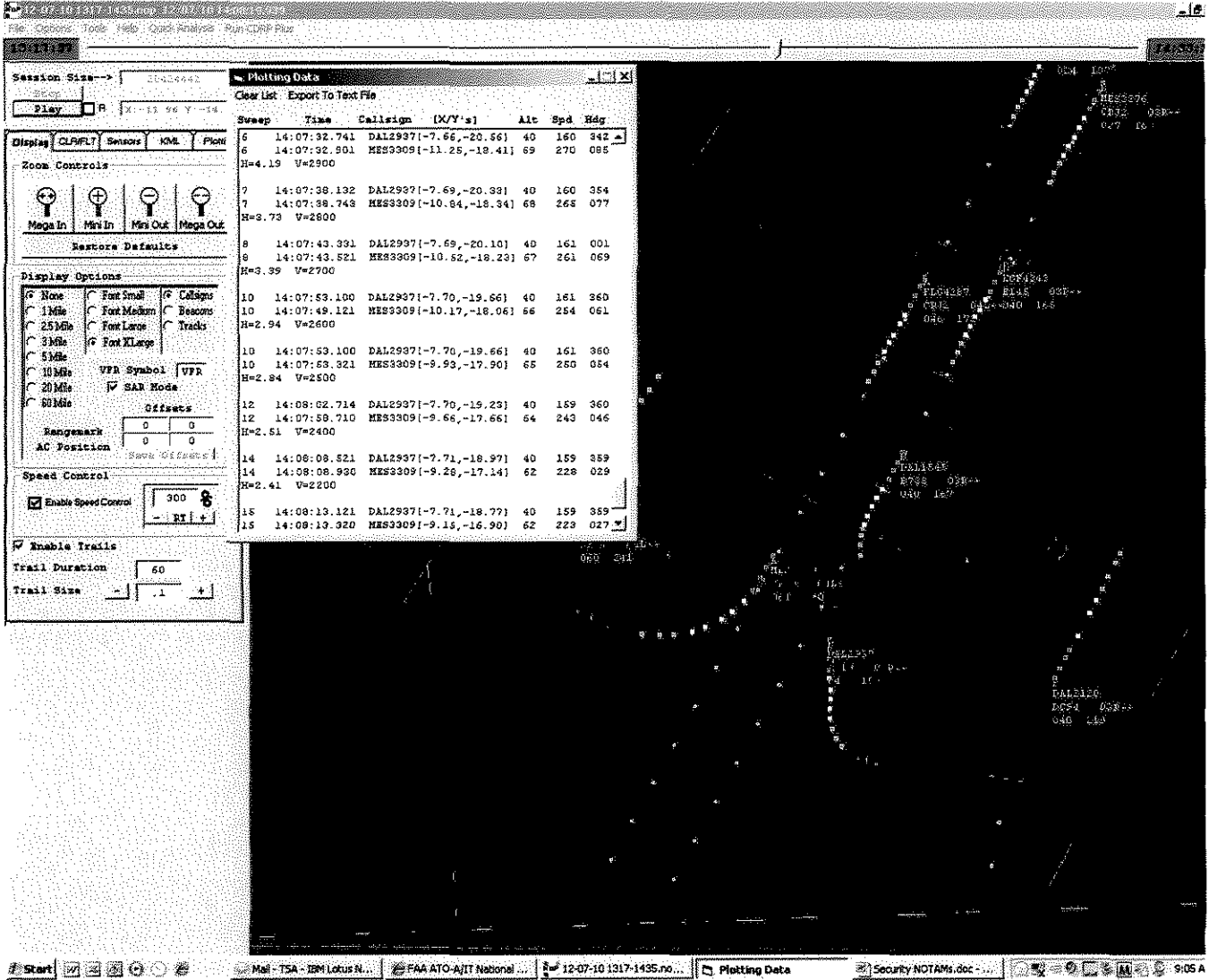
Display Options
 Line Font Small Colsops
 1Mile Font Medium Seasons
 2.5Mile Font Large Tracks
 3Mile Font Large
 5Mile
 10Mile VFR Symbols VFR
 20Mile SAR Mode
 50Mile
 Rangenmark
 AC Position Save Offsets

Speed Control
 Enable Speed Control 300
 - 21 +

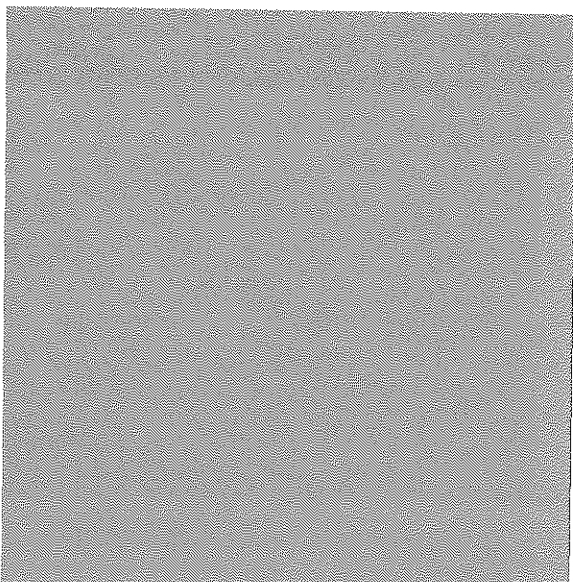
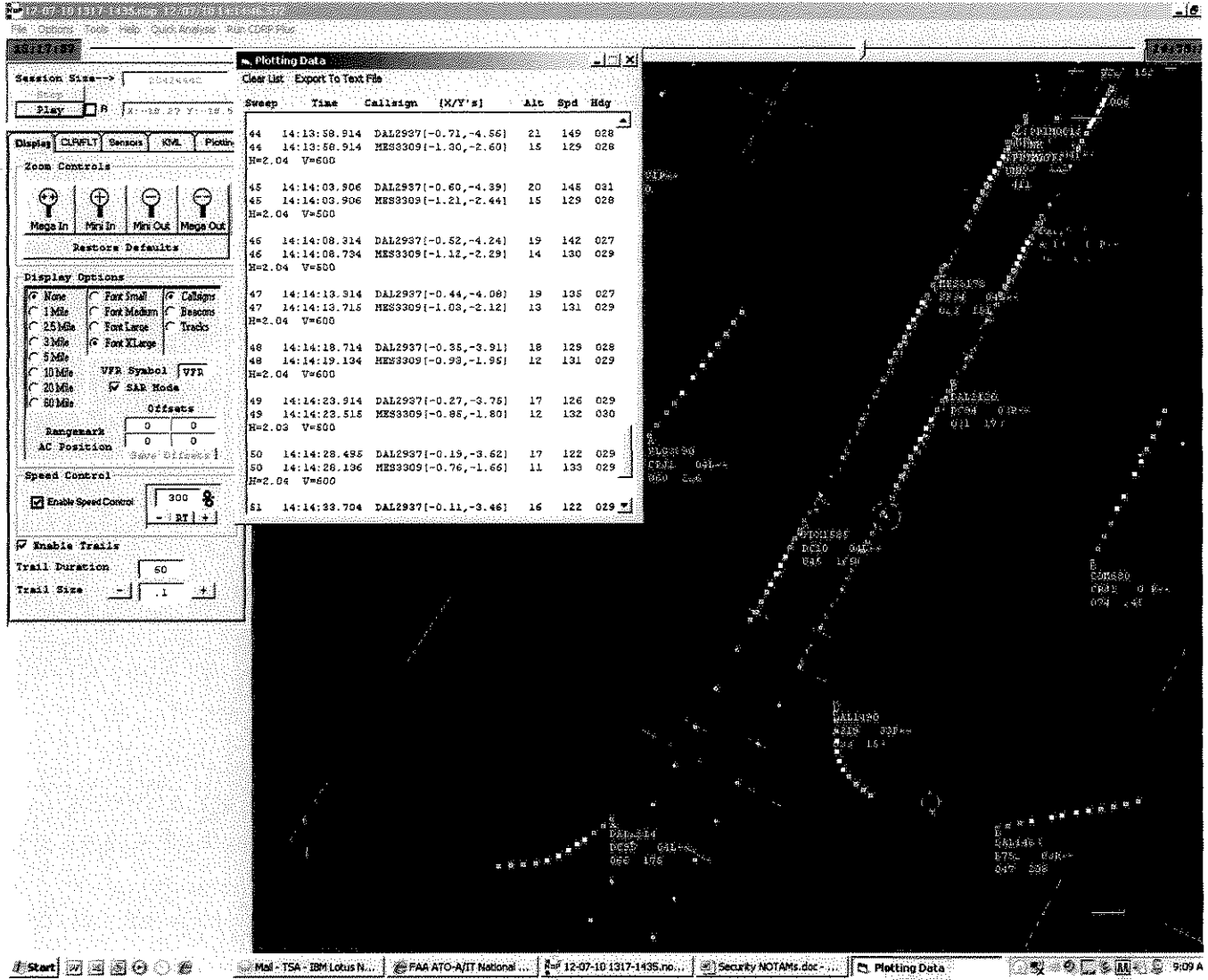
Enable Trails
 Trail Duration 60
 Trail Size .1

Sweep	Time	CallSign	[X/Y's]	Alt	Spd	Hdg
H=1.90	V=400					
67	14:16:08.519	DAL2120	[-0.07,-3.41]	16	160	029
67	14:16:08.916	HSS3178	[-0.76,-1.64]	11	131	029
H=1.89	V=500					
68	14:16:19.735	DAL2120	[0.03,-3.21]	15	147	028
68	14:16:14.315	HSS3178	[-0.66,-1.47]	11	130	029
H=1.88	V=400					
69	14:16:19.695	DAL2120	[0.14,-3.01]	14	144	028
69	14:16:18.916	HSS3178	[-0.59,-1.33]	10	129	028
H=1.83	V=400					
70	14:16:24.115	DAL2120	[0.22,-2.85]	14	144	029
70	14:16:24.715	HSS3178	[-0.49,-1.14]	9	128	028
H=1.85	V=500					
71	14:16:29.115	DAL2120	[0.32,-2.68]	13	142	028
71	14:16:28.535	HSS3178	[-0.43,-1.03]	9	126	028
H=1.81	V=400					
72	14:16:38.516	DAL2120	[0.40,-2.53]	12	141	028
72	14:16:38.515	HSS3178	[-0.38,-0.88]	8	124	028
H=1.81	V=400					
73	14:16:38.705	DAL2120	[0.49,-2.35]	11	138	029
73	14:16:38.935	HSS3178	[-0.26,-0.72]	8	122	030
H=1.80	V=300					





no point w/o turn.



Session Size: C0524442

Play []

Display: CLMFLT | Sensors | XML | Plotting

Zoom Controls: Mega In, Min In, Min Out, Mega Out

Display Options:

- Range: 1Mile, 25Mile, 3Mile, 5Mile, 10Mile, 20Mile, 50Mile
- Font: Small, Medium, Large, XLarge
- VFR Symbol, SAR Mode, Crisets
- RangeMark, AC Position

Speed Control:

- Enable Speed Control [x] 300

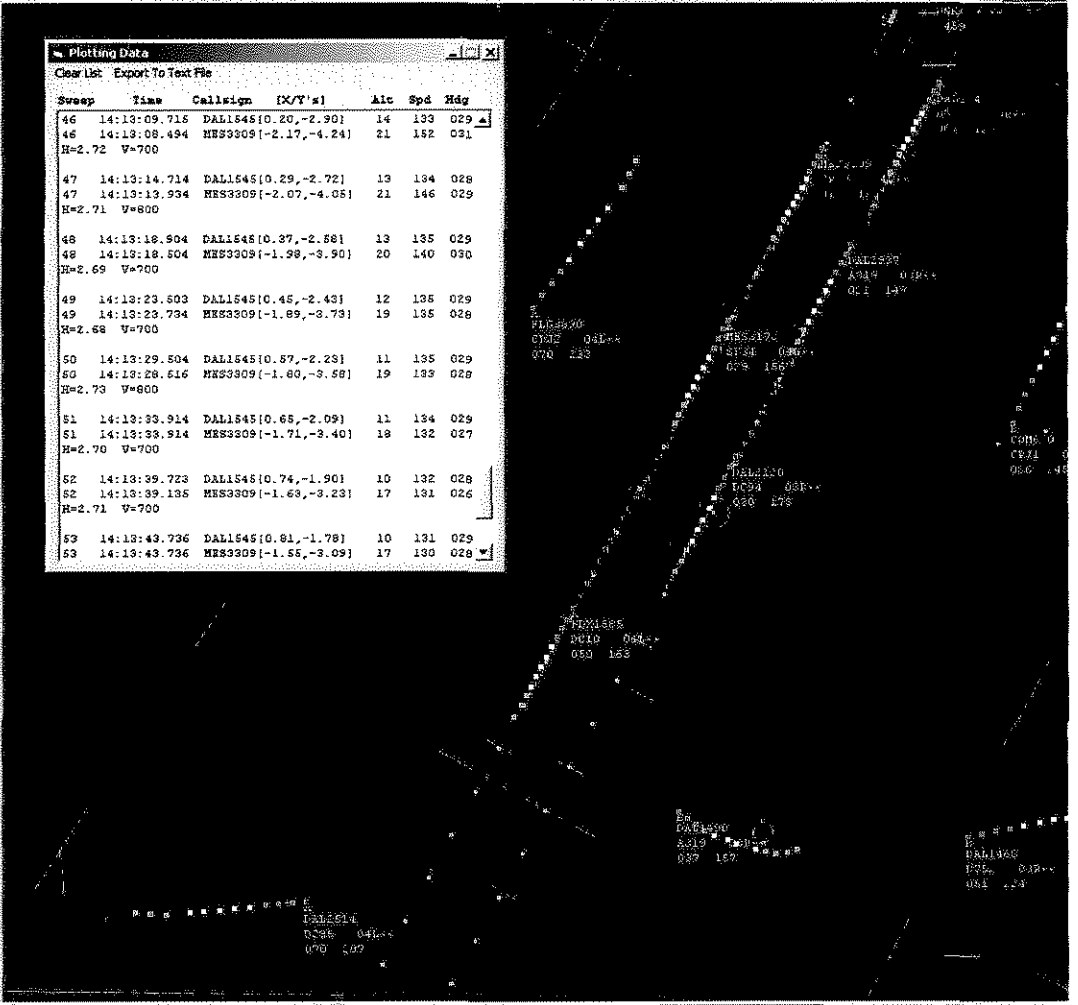
Enable Trails [x]

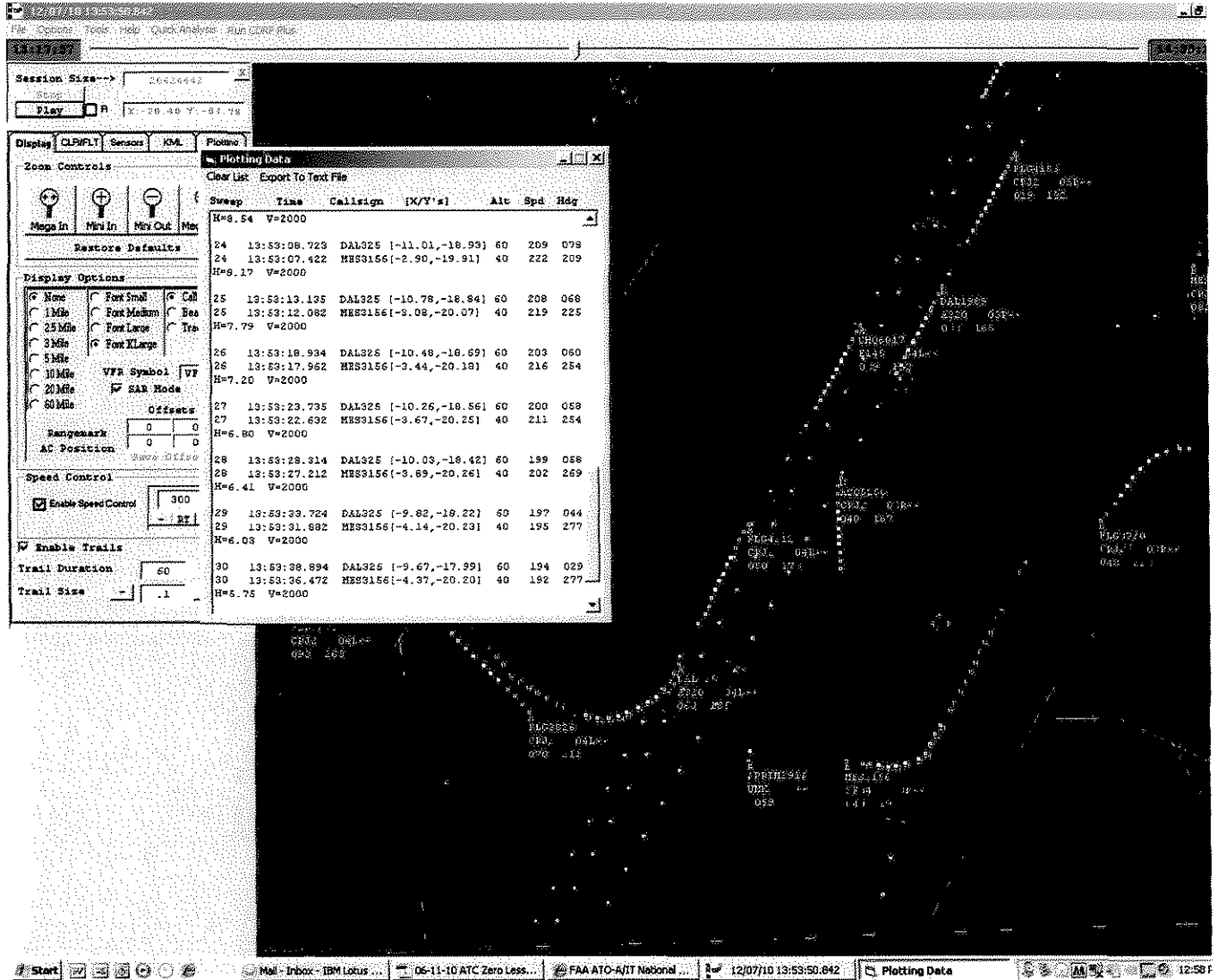
- Trail Duration: 60
- Trail Size: .1

Plotting Data

Clear List Export to Text File

Sweep	Time	CallSign	[X/Y's]	Alt	Spd	Hdg
46	14:13:09.715	DALL545	[0.20, -2.90]	14	133	029
46	14:13:08.494	HES3309	[-2.17, -4.24]	21	152	021
H=2.72 V=700						
47	14:13:14.714	DALL545	[0.29, -2.72]	13	134	028
47	14:13:13.934	HES3309	[-2.07, -4.05]	21	146	029
H=2.71 V=600						
48	14:13:18.504	DALL545	[0.37, -2.58]	13	135	029
48	14:13:18.504	HES3309	[-1.98, -3.90]	20	140	030
H=2.69 V=700						
49	14:13:23.503	DALL545	[0.45, -2.43]	12	136	029
49	14:13:23.734	HES3309	[-1.89, -3.73]	19	155	028
H=2.68 V=700						
50	14:13:29.504	DALL545	[0.57, -2.23]	11	135	029
50	14:13:28.516	HES3309	[-1.80, -3.58]	19	153	028
H=2.73 V=600						
51	14:13:33.914	DALL545	[0.65, -2.09]	11	134	029
51	14:13:33.914	HES3309	[-1.71, -3.40]	18	152	027
H=2.70 V=700						
52	14:13:39.723	DALL545	[0.74, -1.90]	10	132	028
52	14:13:39.135	HES3309	[-1.63, -3.23]	17	151	026
H=2.71 V=700						
53	14:13:43.736	DALL545	[0.81, -1.78]	10	131	029
53	14:13:43.736	HES3309	[-1.55, -3.09]	17	150	028





If you say a 2°
 Turn is straight,
 @ fastest speeds of
 203 kts =
 0.56nm

12-07-10 1317 1435.no...
 Session Size: 2042144
 Play M - 12 81 Y - 31 39

Display CLRF/LT Sensors KM Plotting

Zoom Controls
 Mega In Mini In Mini Out Mega Out
 Restore Defaults

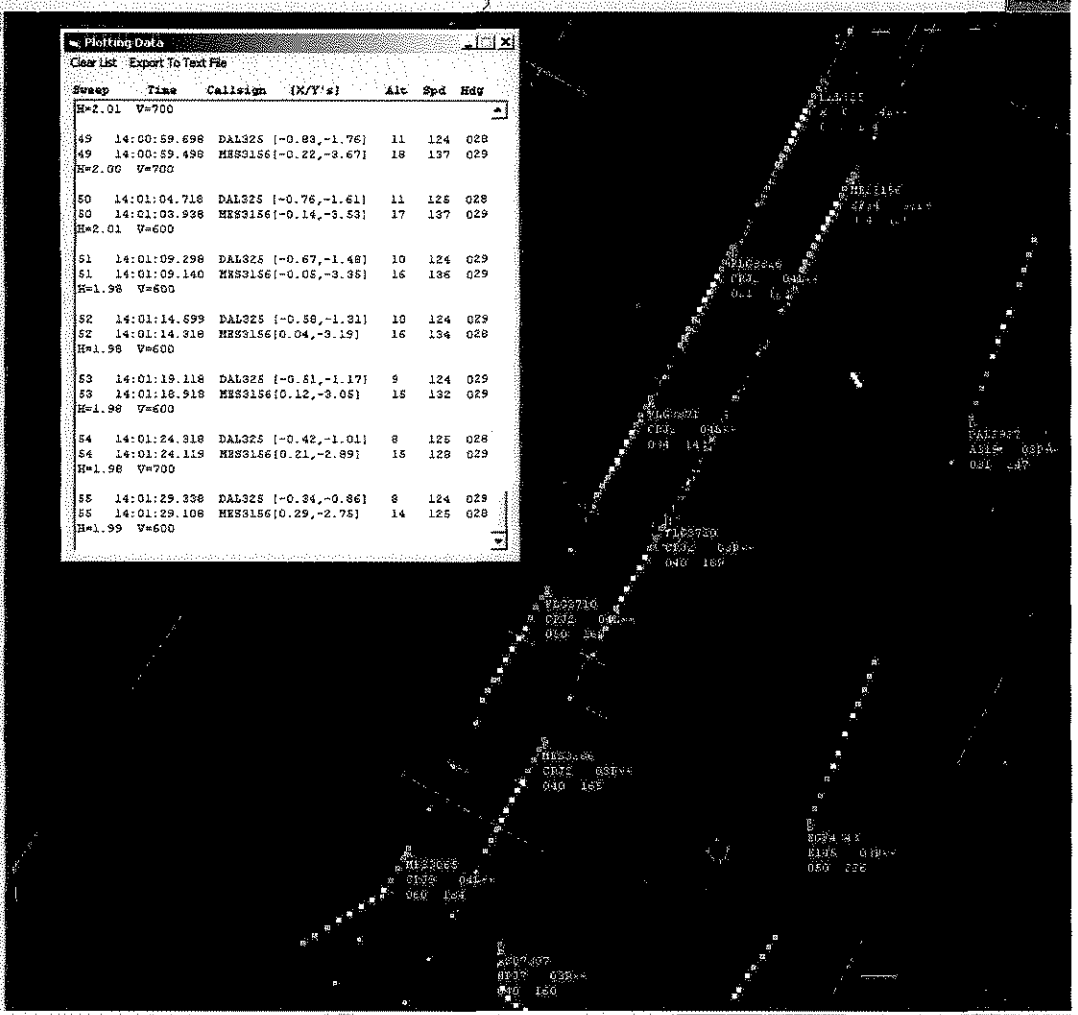
Display Options
 None Font Small Collage
 1Mile Font Medium Beacons
 25Mile Font Large Tracks
 3Mile Font XLarge
 5Mile
 10Mile VFR Symbol VFR
 20Mile SAR Mode
 80Mile
 Offsets
 Rangesmark: 0 0
 AC Position: 0 0
 Save Offsets

Speed Control
 Enable Speed Control 300
 - RT +

Enable Trails
 Trail Duration: 60
 Trail Size: .1

Plotting Data
 Clear List Export to Text File

Sweep	Time	CallSign	(X/Y's)	Alt	Spd	Hdg
H=2.01	V=700					
49	14:00:59.698	DAL325	[-0.83,-1.76]	11	124	028
49	14:00:59.498	MHS3156	[-0.22,-3.67]	18	137	029
H=2.00	V=700					
50	14:01:04.718	DAL325	[-0.76,-1.61]	11	126	028
50	14:01:03.938	MHS3156	[-0.14,-3.53]	17	137	029
H=2.01	V=600					
51	14:01:09.298	DAL325	[-0.67,-1.48]	10	124	029
51	14:01:09.140	MHS3156	[-0.05,-3.38]	16	136	029
H=1.98	V=600					
52	14:01:14.699	DAL325	[-0.50,-1.21]	10	124	029
52	14:01:14.918	MHS3156	[0.04,-3.15]	16	134	028
H=1.99	V=600					
53	14:01:19.118	DAL325	[-0.51,-1.17]	9	124	029
53	14:01:18.918	MHS3156	[0.12,-3.05]	15	132	029
H=1.98	V=600					
54	14:01:24.918	DAL325	[-0.42,-1.01]	8	125	028
54	14:01:24.118	MHS3156	[0.21,-2.89]	15	128	029
H=1.98	V=700					
55	14:01:29.338	DAL325	[-0.34,-0.86]	8	124	029
55	14:01:29.108	MHS3156	[0.29,-2.75]	14	125	028
H=1.99	V=600					



Edit	New Memo	Reply/Reply	Reply/Reply with History	Reply/Reply without Attachment(s)	Reply/Reply to All	Reply/Reply to All with History	Reply/Reply to All without Attachment(s)	Forward	Delete	Copy Into New/New To Do	Copy Into New/New Calendar Entry	Print without Recipients	Go to/Inbox	Go to/Calendar	Go to/To do
------	----------	-------------	--------------------------	-----------------------------------	--------------------	---------------------------------	--	---------	--------	-------------------------	----------------------------------	--------------------------	-------------	----------------	-------------

Tim Funari/AGL/FAA
 04/08/2009 10:13 AM
 To gary F Ancinec/AGL/FAA
 cc joseph.figliuolo@faa.gov, david.ausherman@faa.gov
 bcc
 Subject INFO: My input on role

Mr. Ancinec,

In my 04-02-09 e-mail, where I was conveying thoughts as to what the proposed, new, administrative FLM position might look like, I was suggesting more of an oversight role because I feel it is needed. I also felt, and feel that I have demonstrated exceptional credibility and would have been a highly qualified candidate. To underscore that point, I reviewed a couple of QARs at random, and this is what I found.

In a QAR that CA completed on PE while working jet departure (I did not note the date, but it would have been late March/early April) that was executed because of a query from ZOIB, no deficiencies were noted. However, it appears that Pat assigned the lead aircraft in the sequence that included the subject aircraft "2-8-0 knots or greater." The LOA requires the issuance of 280 knots, and no coordination appears to have been completed. The QAR indicated no controller deficiencies.

In a QAR that KN completed on 04-03-09, regarding COA688 and the actions involved in taking the aircraft off the approach, again no controller deficiencies were identified. In reality, however, when TL cancels the approach clearance, instead of turning the aircraft off the final to the left, he inadvertently turned the aircraft right by instructing him to "fly runway heading." This results in the necessity for an immediate turn back to the localizer a bit later. Todd meant to have the aircraft fly the localizer but did not communicate this correctly. Additionally, C2 had coordinated for a turn back into arrival airspace so as to mitigate impact to the tower. Todd did not do so telling the C2 to have the tower do it. It appears that D21 owned Area 51 at the time.

My intention is simply to bring to light that we are not identifying issues that could and should be identified. It is not to cast aspersions, but a sincere effort to add to the discourse of where we could improve our performance efforts. I hope you receive it in that spirit. If a follow-up to this e-mail is pursued, I ask that it be done with consideration to mitigating adverse effects to myself.

Thanks,

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

14492

QUALITY ASSURANCE REVIEW (QAR)

Today's Date 4/3/09 Initials of Person initiating QAR or receiving inquiry KN

Name of Inquirer _____ Affiliation _____
(if applicable)
Phone # if return call is required _____

Describe event or initiating incident*, including date, approximate time, and call sign(s) if available.

COA688 was overtaking traffic ahead of him on the same localizer (RY44), the monitor controller broke COA688 off the approach in order to maintain separation longitudinally with traffic ahead. COA688 was issued speed reductions in an attempt to maintain the interval.

*Events requiring a QAR: aircraft accident, pilot/vehicle/pedestrian deviations, TCAS RA, inquiries about a specific operation such as by flight crew, FSDO, City, passengers, media, etc., and interfacility traffic management initiatives that cause "No notice ground stops" or "No notice airborne holding".

Make FAA Form 7230-4 entry. "QAR initiated (specific operation) from (date if other than today)."

Proceed with investigation of event/incident. (If support is needed, contact the QA Dept.)

Person conducting investigation KN

Conduct investigation to assess controller's performance during event/incident.

Method(s) used:

- Discussion with controller(s). List initials of personnel TL TD
- Voice tape reviewed. PSN or FREQ 135.0 Time 1749Z to 1755Z
- CDR
- Other (specify) _____

CONTINUED ON REVERSE

Conclusions:

- Exemplary controller performance.
- No controller performance deficiencies identified.
- Controller performance contributed to incident.**
- Controller performance increased the severity of the incident.**
- Controller performance failed to mitigate the initiating incident.**

- Controller performance deficiencies noted; however, not related to incident.**

**Controller's first-level supervisor must determine appropriate corrective action and training to resolve performance deficiency.

First-level Supervisor's summary of action:

Qualif was viewed behind a 5734
TU RY4L. He was slowed by the
monitor but he continued to overtake
his traffic and was pulled out.
Controllers were interviewed and confirmed
my finding. CDK PLOT revealed separation
was maintained. Masaba had to be
slowed because of traffic he was
also following.
initial spacing was acceptable, compression
caused to pull-out

4/3/09

Date of FAA Form 7230-4 entry: "QAR concluded (specific operation) from (date if other than today)" and the initials of the person responsible for conducting the review


- Forward to DTW-1/DTW-2 for review
- Forward to DTW-5 for review.
- Forward to QA for filing. Copies distributed to OM's. _____
- Enter into tracking form.

o 734-955-5042
c 734-674-0072
tim.funari@faa.gov
Gary F Ancinec/AGL/FAA



Gary F Ancinec/AGL/FAA
TCL-DTW, Detroit Metro
ATCT, MI

04/09/2009 03:57 PM

To: Tim Funari/AGL/FAA@FAA
cc: david.ausherman@faa.gov, joseph.figliuolo@faa.gov
Subject: Re: INFO: My input on role 

Tim,

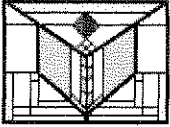
We have looked into the issues you raised in this memo. In both cases, it appears that the actions taken by the OM or FLM conducting the investigation were correct. In the first case your assertion that the lead aircraft was assigned greater than 280 knots is correct. The aircraft that lead to the inquiry from ZOB was assigned 280 knots per the LOA. The intent of this provision is to prevent a gap of less than 10 miles between aircraft closing because the rear aircraft is faster than the front. If the back aircraft is issued 280 knots, then the front aircraft needs to be issued a faster speed to increase the gap between them. We are looking into this matter further to determine if an OD occurred.

In the second case, the controller took action to preserve separation. It may not have been the most effective or easiest way to achieve this, but his actions did accomplish what the controller set out to do. It is up to the individual FLM to determine whether or not the controllers actions were a problem. He determined they were not. I will give the FLM the benefit of the doubt.

While I appreciate your desire to improve facility performance management, these issues need to be brought to the attention of your operations manager in the future. If you are not satisfied with the results of those discussions, you may refer them to the next level of management. Parts of any manager's job are teamwork and working together with their peers. If your fellow FLMs found out that you were critiquing their job performance, I am certain they would harbor hard feelings towards you. Likewise, the OMs can't do their part in managing the performance of the FLMs if they don't have a chance to fix any problems that are identified. Both of these issues hinder management's ability to effectively function as a team.

Please feel free to stop by and discuss this further.

Gary F. Ancinec
Acting Staff Manager
Detroit Metro Tower
TCL - D21
Pho: 734-955-5004
Blackberry: 734-255-7926



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

04/09/2009 05:03 PM

To Gary F Ancinec/AGL/FAA@FAA

cc david.ausherman@faa.gov, joseph.figliuolo@faa.gov

bcc tfunari@charter.net

Subject Re: INFO: My input on role

Mr. Ancinec,

I may not totally understand your answer, but I want to take a moment to clarify a thing or two, if I may.

With regard to the assigned speed on departure, I have reproduced Mr. Auxier's e-mail below. He makes the issue pretty clear and has directed all FLMs to rebrief the controllers. I am not asserting that PE did not ensure separation, I am asserting he did so on other than the LOA required direction w/o coordination. This was evident on the recording that CA had indicated he had reviewed.

All: In your in-baskets is a copy of page 3 of the LOA between ZOB and D21. Highlighted is the following:

- **Jet departures with less than ten (10) MIT must be assigned 280 kts.**

Unless APREQ or coordinated, there is no exception, we must follow the LOA. I do not believe this was the intent of this paragraph, but we do not have the intent documented, thus we cannot alter the literal verbiage of this or any LOA.

Therefore, if you are sequencing departures with less than 10 MIT, all aircraft must be assigned 280 kts, this includes **the first aircraft in the sequence**. Any other speed shall be coordinated with ZOB...

Please ensure all members of your team understand this requirement.

NOTE: We have addressed this issue with ZOB and are awaiting final draft of a new D21/ZOB LOA

Please see me with any questions???????

cd

With regard to the second QAR, I will stand by my belief that TL did not realize he had instructed the aircraft to fly runway heading. Whether he did or did not, however, I fail to understand how one could believe that putting the aircraft on a vector that results in the necessity for an immediate turn shortly thereafter is acceptable performance. I'll just leave it at that.

My point, in bringing this to you, was to follow-up on our past conversations. I wanted to utilize these examples to underscore why I felt oversight was in order. I guess you think these are not good examples.

Lastly, I am not of the understanding that whistle-blowing requires following the chain-of-command. You are in control of who becomes aware of my observations. The repeated attempts to link my efforts there with a lack of teamwork or with a failure to support the management team seem, to me, to be inappropriate.

Tim Funari
FLM
TCL-D21

Edit	New Memo	Reply/Reply	Reply/Reply with History	Reply/Reply without Attachment(s)	Reply/Reply to All	Reply/Reply to All with History	Reply/Reply to All without Attachment(s)	Forward	Delete	Copy Into New/To Do	Copy Into New/Calendar Entry	Print without Recipients	Go to/Inbox	Go to/Calendar	Go to/To do
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Earl Grand/AGL/FAA
 04/13/2009 02:04 PM EDT

To: Cliff Auxier/AGL/FAA@FAA, Thomas Boland/AGL/FAA@FAA
 cc: Joseph Figliuolo/AGL/FAA@FAA, Gary F Ancinec/AGL/FAA@FAA, Randy Olson/AGL/FAA@FAA, Lisa Green/AGL/FAA@FAA, jblow@nateca.net, Carl Burton/AGL/FAA@FAA, Dan Bussey/AGL/FAA@FAA, Tim Funari/AGL/FAA@FAA, Thomas F Gill/AGL/FAA@FAA, Tom Kuhn/AGL/FAA@FAA, Tom Murphy/AGL/FAA@FAA, Kenneth J Larson/AGL/FAA@FAA, Robert J Sawyer/AGL/FAA@FAA
 bcc:
 Subject: OD Discovered during Audit

An Operational Deviation was filed today (4/13) as a result of an investigatory audit of a QAR that was completed on 3/26/09.

The deviation was charged to Pat Eberhart while working East Jet on 3/26 and occurred at 1652Z.

AWI3972 (CRJ2) was an OCTUS departure climbing to 13,000. Controller instructed aircraft to increase speed to 280 kts or **GREATER** and contact ZOB. EGF4668 (E135) was approximately seven miles enroute, also filed over OCTUS and assigned a speed of 280 kts. The ZOB/D21 LOA (paragraph 6a(2)) states that jet departures with less than 10 MIT must be assigned 280 kts.

Please inform the respective employee about the event and obviously offer ATSAP reporting.

Randy and/or Lisa will need a statement from the employee, following review of the reply.

Earl