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

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

Memorandum

U.S. Department of Transportation
Office of the Secretary
of Transportation
Office of Inspector General

Subject: ACTION: Review of FAA's Safety Oversight of Airlines and Use of Regulatory Partnership Programs
Federal Aviation Administration
Report Number AV-2008-057

Date: June 30, 2008

From: Calvin L. Scovel III
Inspector General

Reply to Attn. of: JA-1

To: Acting Federal Aviation Administrator

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

The whistleblower allegation focused on SWA's failure to follow a critical FAA airworthiness directive (AD) and an FAA inspector's role in allowing the air carrier to continue flying aircraft in violation of the AD. The FAA directive[1] in this case required SWA to inspect the fuselages of its Boeing 737s for potential cracks that could lead to rapid decompression and fatal accidents. FAA issued this directive after an Aloha Airlines 737 lost a major portion of its hull while in flight at 24,000 feet in 1988, resulting in one fatality and multiple injuries. The Chairman also requested that we determine whether FAA took corrective actions in a timely manner.

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

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

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

We testified before the House Committee on Transportation and Infrastructure regarding the SWA matter on April 3, 2008.[2] We subsequently testified before two Senate subcommittees: the Senate Committee on Commerce, Science, and Transportation, Subcommittee on Aviation Operations, Safety, and Security on April 10, 2008,[3] and the Senate Committee on Appropriations, Subcommittee on Transportation, Housing and Urban Development, and Related Agencies on April 17, 2008.[4]

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

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

BACKGROUND

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

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

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

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

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

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

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

SUMMARY OF RESULTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Finally, it appears that FAA management fostered a culture whereby air carriers were considered the primary customer of its oversight mission instead of the flying public. Satisfying customer requirements is a key tenet of the ISO 9001 Quality

Standards. To meet this requirement, FAA announced its Customer Service Initiative in 2003, which defined its customers as the people and companies requesting FAA certification, other aviation services, or information related to the products and mission of the FAA. The initiative, however, was geared toward airlines, repair stations, and other commercial operators—not the flying public.

The SWA case appears to illustrate that FAA's definition of its customer has had a pervasively negative, although unintended, impact on its oversight program. FAA must ensure its air carrier oversight mission clearly identifies the flying public as a primary stakeholder and beneficiary of its inspection efforts. FAA should commit to this in writing and communicate it to all FAA inspection staff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

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

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

3. Develop procedures for periodically rotating supervisory inspectors to ensure reliable and objective air carrier oversight.
4. Implement post-employment guidance that includes a "cooling-off" period (e.g., 2 years) that prohibits an FAA inspector hired at an air carrier he or she previously inspected from acting in any type of liaison capacity between FAA and the carrier.
5. Ensure its air carrier oversight mission clearly identifies the flying public as a primary stakeholder and beneficiary of its inspection efforts; FAA should commit to this in writing and clearly communicate it to all FAA inspection staff.
6. Implement a process to monitor field office inspections and alert local, regional, and Headquarters management to overdue inspections so that immediate corrective actions can be taken.
7. Create a national review team to conduct periodic quality assurance reviews of FAA's oversight of air carriers to ensure that (a) appropriate processes and procedures are being applied consistently and (b) pertinent policies, laws, and regulations are being followed.

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

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

AGENCY COMMENTS AND OIG RESPONSE

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

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

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

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

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

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

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

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

- Revise FAA Order 8900.1, Flight Standards Information Management System, to require field office management to sign off on acceptance of a VDRP report and ensure that the operator has completed the comprehensive fix appropriately before closing out the VDRP report. FAA published interim guidance to this effect on May 1 and plans to incorporate this policy change into permanent guidance by September 30, 2008.

- Amend FAA Order 8900.1 and the VDRP Advisory Circular to emphasize reviewing the comprehensive fix proposed by the operator to ensure it addresses the issue being reported. FAA will also update inspector guidance to ensure principal inspectors and management consider the nature of each report, including repeated reports of the same regulation. FAA plans to complete this action by May 1, 2009.

- Initiate a rulemaking to establish a 2-year cooling-off period for FAA inspectors. The Rulemaking Project Record, which starts the rulemaking process, was approved on May 15.

- Reiterate its commitment to the safety of the flying public by having the Associate Administrator for Aviation Safety visit every FAA Region.

- Modify its Aviation Safety Dashboard to show the percentage of the ATOS inspections assigned and completed, those that have not been assigned, and the reasons for the unassigned. FAA agreed to send Alert Notifications to the regional division managers at the end of each calendar quarter.

- Revise its guidance to require Air Carrier Evaluation Program audits to be conducted on a regular basis.

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

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

ACTIONS REQUIRED

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

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

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

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

EXHIBIT A. SCOPE AND METHODOLOGY

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

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

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

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

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

EXHIBIT B. AGENCIES VISITED OR CONTACTED

Federal Aviation Administration

Headquarters:

Flight Standards Service	Washington, DC

Regional Offices:

Southwest Regional Office	Fort Worth, TX
FAA Security and Hazardous Materials Division	Fort Worth, TX

Certificate Management Offices (CMO):

Southwest Airlines CMO	Irving, TX
American Airlines CMO	Fort Worth, TX

Flight Standards District Office (FSDO):

Dallas-Fort Worth FSDO	Fort Worth, TX

Air Carrier

Southwest Airlines	Dallas, TX

APPENDIX. MANAGEMENT COMMENTS

Federal Aviation Administration

Memorandum

Date: June 24, 2008

To: Matthew E. Hampton, Deputy Assistant Inspector General for Aviation and Special Program Audits

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

Prepared by: Anthony Williams, x79000

Subject: OIG Draft Report: Review of FAA's Safety Oversight of Airlines and Use of Regulatory Partnership Programs

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

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

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

On May 1, the FAA published interim guidance for operators in Information for Operators (InfO) 08021, explaining both the requirement for FAA management sign-off and for a key management

official in the airline to sign-off on the VDRP submission. We will include this change in an update of Advisory Circular 00-58, Voluntary Disclosure Reporting Program, also by September 30.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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