THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

March 5, 2010

William E. Reukauf
Associate Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036

Re: OSC File No. DI-08-2082

Dear Mr. Reukauf:

I am responding to a letter of July 10, 2008, from former Special Counsel Scott Bloch, which referred for investigation safety concerns raised by John Keller, a former Aviation Safety Inspector at the Federal Aviation Administration's (FAA's) Grand Rapids, Michigan, Flight Standards District Office (FSDO). Mr. Keller alleged that FAA employees at the Grand Rapids FSDO altered investigatory findings concerning a fatal helicopter crash to suppress evidence of inadequate maintenance and improperly delayed inspections over four years prior to the crash.

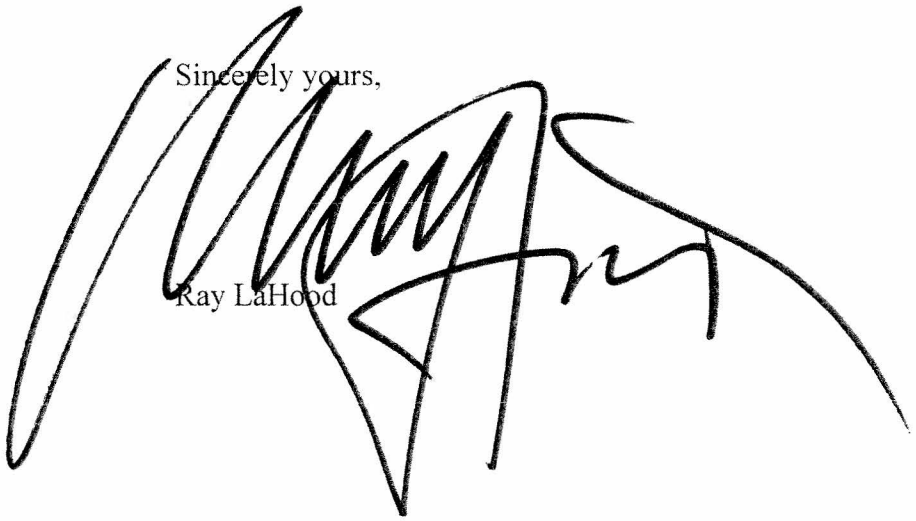
Former Secretary Peters delegated investigation of this matter to the Department's Office of Inspector General (OIG). The OIG's investigation was held in abeyance pending resolution of a criminal investigation conducted by the United States Attorney's Office (USAO) for the Northern District of Florida. On or about May 2009, the USAO advised the OIG that given the status and basis of the pending criminal investigation, they did not see any conflict with the OIG conducting its administrative investigation. The OIG accordingly commenced its investigation of this matter. Enclosed are the OIG's Report of Investigation and the FAA's response.

In summary, the OIG investigation did not substantiate the allegations. Mr. Keller raised safety concerns related to the events leading up to and action by FAA after a helicopter accident on May 16, 2008, in Comstock, Michigan, of a Fairchild-Hiller model FH-1100 (FAA aircraft registration number N5049F). Mr. Keller was, for a short period, assigned as FAA's Investigator-in-Charge of the accident investigation, which was led by the National Transportation Safety Board. He subsequently filed his disclosure with OSC.

OIG's investigation found that FAA provided legitimate explanations for actions taken prior to the fatal accident and for the statements and actions of FAA managers in the days following the accident. The investigation revealed that Mr. Keller's allegations were not supported by the evidence. He made certain unfounded inferences that were likely influenced by personal issues, his lack of experience managing a fatal accident investigation and his lack of familiarity with his role as Investigator-in-Charge in parallel regulatory and criminal proceedings.

By the enclosed memorandum, the FAA Associate Administrator for Aviation Safety accepted the OIG's findings.

Sincerely yours,



Ray LaHood

Enclosures

Federal Aviation Administration

Memorandum

Date: February 12, 2010

To: Robert A. Westbrooks, Acting Assistant Inspector General for Special Investigations and Analysis, JI-3

From: Margaret Gilligan, Associate Administrator for Aviation Safety, AVS-1

Prepared by: John M. Allen, Director, Flight Standards Service, AFS-1, X-78237

Subject: Office of the Inspector General (OIG) Investigation # I08Z000349SINV re: Grand Rapids, MI, Flight Standards District Office (GRR FSDO)

After reviewing the report for the above-referenced investigation, my senior management team in the Flight Standards Service (AFS) advised me to accept the report with no proposed changes or comments. I concur.

Regarding a statement of any corrective action as a result of this investigation, my AFS senior management team advised me no such action is warranted by the findings in the report. I concur.

While we do not see any immediate or near term action required on the part of FAA, please note we've recently filled the position of the AFS regional division manager for the Great Lakes Region. As such, we'll share the report with that new division manager who'll then share the report with the AFS regional management team as well as with the GRR FSDO management team for their consideration of any lessons learned.

If you have any questions or desire additional information, please have a member of our staff contact Mr. Michael McCafferty, AFS Executive Officer, at (202) 267-3928 or by e-mail at michael.mccafferty@faa.gov.

U.S. Department of Transportation
Office of Inspector General

REPORT OF INVESTIGATION	INVESTIGATION NUMBER #I08Z000349SINV	DATE Jan. 25, 2010
TITLE Re: Grand Rapids, MI FSDO	PREPARED BY: Barbara L. Barnet Senior Special Agent Special Investigations and Analysis, JI-3 U.S. Department of Transportation Office of Inspector General	STATUS FINAL
	DISTRIBUTION	APPROVED BY: JI-3

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BACKGROUND

On May 16, 2008, a Fairchild-Hiller model FH-1100 helicopter (FAA aircraft registration number N5049F) collided with a tree and terrain in Comstock, Michigan, killing the pilot who was the sole occupant. The pilot purchased the helicopter the day before the accident. The National Transportation Safety Board (NTSB) and FAA conducted a post-accident investigation. The probable cause of the accident was determined to be "a loss of engine power in flight due to fuel exhaustion."

In the months prior to the accident, issues related to N5049F's airworthiness surfaced as a result of a large scale and complex regulatory investigation by FAA and a parallel criminal investigation by the Office of Inspector General (OIG). These investigations focused on the helicopter's manufacturer, its associated aircraft companies, and the FH-1100 helicopter fleet in general for the sale and installation of suspected unapproved aircraft parts (SUPs). During the investigations, N5049F was identified as *possibly* containing SUPs. In January 2008, the helicopter's previous owner was notified by FAA that N5049F *may* contain SUPs.

At the time of the accident, the whistleblower was an Aviation Safety Inspector on probationary status in the Grand Rapids Flight Standards District Office (FSDO). He responded to the accident scene with a team of inspectors, and he was subsequently assigned as FAA's Investigator-in-Charge of the accident investigation. During the accident investigation, the whistleblower learned of the SUPs investigations.

Within two weeks, FSDO managers reassigned the whistleblower following disagreements with management about the accident investigation and other issues. Following the reassignment, he filed a disclosure with the U.S. Office of Special Counsel (OSC). He alleged that FAA had been lax in its safety oversight responsibilities of N5049F prior to the crash, and following the crash FAA officials altered investigative findings in an effort to shield FAA from embarrassment.

OSC referred the investigation to former U.S. Department of Transportation Secretary Mary E. Peters on July 10, 2008. The Secretary delegated investigative responsibility to the OIG. The investigation was stayed pending completion of the criminal investigation. In May 2009, we determined that the criminal investigation was near completion and that this investigation could proceed without compromising any criminal cases. Attachment 1 describes the methodology of our investigation. Attachment 2 is a Timeline of Significant Events.

SYNOPSIS

We are unable to substantiate the allegations by a preponderance of the evidence. Legitimate explanations were provided for actions taken by FAA prior to the fatal accident and for the statements and actions of FAA managers in the days following the accident. Inferences made at the time by the whistleblower were likely influenced by personal issues, his lack of experience managing a fatal accident investigation, and his lack of familiarity with his role as Investigator-in-Charge in parallel regulatory and criminal proceedings.

Below are the details of our investigation.

DETAILS:

Allegation 1: FAA managers attempted to conceal information following a fatal helicopter crash on May 16, 2008, in Comstock, MI, in an effort to shield FAA from embarrassment.

FINDINGS

In the OSC investigative referral memo and in our later interview, the whistleblower alleged an FAA supervisor made various statements concerning the investigation that the whistleblower interpreted at the time as an attempt to shield FAA from embarrassment. The whistleblower also alleged that information he originally included in a briefing paper and an FAA Accident/Incident Form was substantially edited by the supervisor. Our investigation found three significant factors that affected the whistleblower's interpretation of statements and actions and caused him to incorrectly infer that FAA managers were attempting to conceal information.

First, this was the whistleblower's first accident investigation as Investigator-in-Charge. He worked on five previous accident investigations as a team member and as part of his on-the-job training. He told investigators he had no previous experience interacting with multiple agencies, including on-site coordination with NTSB and communication with criminal law enforcement organizations. Moreover, this was his first investigation involving a fatality. As a result of these and other factors, the whistleblower told investigators that he was "overly cautious" during the investigation.

Second, it appears the whistleblower was unclear of his role in the investigative process, and unaware of information that was known to others and being shared in the regular course of business. His role as Investigator-in-Charge was limited to representing the FAA during the accident investigation, supporting NTSB in any way to help it determine probable cause of the accident, ensuring FAA's nine areas of accident investigation responsibilities were addressed, and coordinating FAA participants' activities. OIG investigators handling the SUPs investigation were fully aware of the accident. In cases

such as these, OIG investigators rely on NTSB's official determination of probable cause of the accident and that investigation generally takes precedence over a criminal investigation.

Third, we found that while the whistleblower acted in good faith, personal issues affected his interpretation of statements and actions of his supervisor and caused him to incorrectly infer that the supervisor was attempting to conceal information. These issues were addressed in a related OSC proceeding and are known to both FAA and OSC. They are not discussed in detail here as they are beyond the scope of this investigation.

Within this context, the whistleblower specifically alleged that his supervisor instructed him as follows:

- The whistleblower should not be forthcoming with any information regarding the fatal crash investigation, but instead respond to questions only after being asked by NTSB and OIG.
- All information must flow through the supervisor, to the FSDO manager, and then the regional office.
- The whistleblower should not make the FAA Regional Director "look bad" and should not share any information about the helicopter investigation unless cleared by the regional office.

The supervisor acknowledged to investigators making most of these statements, but he explained his words must be put in context. The supervisor stated that the whistleblower was not focusing on his responsibilities as the Investigator-in-Charge. In this role, he needed to take numerous factors into consideration while conducting the investigation. According to the supervisor, the whistleblower became consumed by the ongoing SUPs investigation, which was the responsibility of FAA Southern Region Special Evaluation and Inspection Team (SEIT). The supervisor stated that he constantly had to remind the whistleblower about his specific responsibilities relative to the accident investigation. The supervisor opined that the whistleblower may have taken that to mean that he was not to provide information to NTSB or OIG. The supervisor admitted to investigators that he instructed the whistleblower to communicate up the chain of command. He explained that this instruction was the result of a loss of confidence in the whistleblower's ability to make reasonable decisions, the complexity of the investigation, and multiple agency involvement with differing objectives. The supervisor recalled that the whistleblower responded to this instruction by declaring that there was something being covered-up.

The supervisor could not recall specifically telling the whistleblower not to make the FAA Regional Director "look bad," but he admitted he could have said something to that effect. He explained to investigators that at the time he was concerned about the whistleblower's unpredictable behavior.

The whistleblower also alleged that his supervisor altered certain investigative records as follows:

- The whistleblower was requested to complete a briefing on the accident. A draft was provided to his supervisor who deleted much of the information.

- The whistleblower was asked to complete a FAA Accident/Incident Report. A draft was provided to his supervisor who deleted much of the information. The whistleblower also asserts that his supervisor insisted on including information questioning the status of the deceased pilot's medical condition and the status of his FAA medical certification at the time of the accident.

The whistleblower's supervisor acknowledged that he did, in fact, delete much of the information included in these two reports. According to the supervisor, briefing papers are used to inform headquarters and regional managers and public information personnel of basic and factual information learned about the accident. The Accident/Incident Report Form is used to enter information into the FAA accident/incident database.

The supervisor stated that it was actually his responsibility to prepare the briefing paper, following a regionally-approved format. The supervisor prepared the briefing paper relying on information provided by the whistleblower. The supervisor admitted deleting much of the whistleblower's narrative on both records. He explained that the documents incorrectly contained information related to investigative activity, statements of facts that had not yet been substantiated by NTSB, information that was speculative in nature, and other information that was not appropriate for these types of records.

We found that while detailed information was deleted from the two drafts, the whistleblower's information was preserved in the FAA's Program Tracking and Reporting Subsystem (PTRS). PTRS is FAA's official database of inspectors' detailed work activities. This information is available for review by other inspectors in the Flight Standards Division. According to the supervisor, the PTRS was the appropriate database to include such detailed information.

The supervisor advised investigators that while the SUPs investigation may have had a bearing on the accident, the whistleblower concluded too early in the investigation that an unapproved part or a maintenance issue caused the accident. The supervisor admitted that he told the whistleblower that the pilot's medical condition also had to be considered as a possible cause of the crash. The supervisor told investigators that soon after this conversation the pilot's medical condition was ruled out as a cause and he made no further attempts to raise this issue.

Allegation 2: Prior to the accident, FAA was lax in its oversight of the subject helicopter, and FAA should have taken action to withdraw its airworthiness certification.

FINDINGS

We were unable to substantiate this allegation.

The whistleblower specifically alleged the following:

- The engine on the helicopter was categorized as experimental and therefore not approved for use.

FAA records reflect that at the time of the accident investigation the engine in N5049F was, in fact, listed as experimental. The FAA Southern Region SEIT subsequently reviewed the records and conducted a physical inspection. The SEIT determined the experimental categorization to be an error. The engine on N5049F was, in fact, the appropriate engine for the helicopter.

- There were an unusual number of attempts by FAA to inspect the helicopter's parts without success and the owner of N5049F lodged complaints against inspectors in what appeared to be a successful delay of inspections.

We found no evidence to support this statement. We found that N5049F was, in fact, the subject of heightened regulatory scrutiny as a result of the SUPs investigation. (*See*, Attachment 2, Timeline of Significant Events)

In late 2007, as part of the SUPs investigation involving the Fairchild-Hiller FH-1100 fleet, the FAA Southern Region SEIT identified N5049F as possibly containing SUPs. SEIT targeted N5049F for re-examination, as provided for in Title 49 U.S. Code § 44709(a) (*Reinspection and Reexamination*). This reexamination was conducted on January 30-31, 2008. A letter of discrepancy was issued to N5049F's owner following a random review of the historical records and a limited visual inspection. The inspection resulted in voluntary surrender of a copy of the helicopter's airworthiness certificate.

Just prior to the inspection, however, the owner of N5049F sought a Letter of Authorization from the Minneapolis FSDO to conduct air tour operations utilizing N5049F. Not knowing about the pending investigation by the Southern Region SEIT, the Minneapolis FSDO issued a Letter of Authorization on February 19, 2008. On February 21, 2008, after learning of the investigation, the Minneapolis FSDO notified N5049F's owner, via e-mail, that his "helicopter was no longer airworthy . . . please be reminded that you may not fly passengers unless you get your airworthiness back in the standard category."

On February 25, 2008, the Southern Region SEIT issued a lengthy letter to N5049F's owner reiterating their previous conversations and the owner's responsibility to ensure his helicopter's airworthiness. Unsatisfied with FAA's responses, in particular the progression of the SUPs investigation, N5049F's owner filed a Customer Service Initiative complaint with FAA on March 1, 2008. He expressed his concerns and frustration with the investigative process. He specifically requested N5049F's airworthiness certificate copy be returned to him. He also sought the assistance of the office of Congressman Ron Kind (D-WI), and Congressman Kind's office subsequently asked FAA about the status of N5049F's airworthiness certificate.

On March 13, 2008, after internal discussion including consultation with the FAA Southern Region's Legal Division, FAA returned N5049F's airworthiness certificate copy to the owner. FAA determined it did not have a legal basis to retain the certificate and lacked sufficient evidence to pursue legal action at that time. The FAA was still investigating the SUPs matter and had not definitively determined the parts in question were, in fact, "unapproved." We found that there is no action FAA can take, such as revoking the helicopter's certificate, while a part is only considered a "suspected unapproved part." It should be noted that other FH-1100 airworthiness certificates, also voluntarily surrendered, were returned for the same reasons as N5049F.

In a letter that accompanied the airworthiness certificate copy, FAA advised the owner that the returned certificate was only a copy, not an original, of a standard airworthiness certificate. Moreover, that certificate had actually been superseded by a Restricted Category certificate. The letter emphasized that the SUPs issue remained under investigation. FAA also informed the owner that operation of the helicopter *might* constitute a violation of the Federal Aviation Regulations.

N5049F's owner subsequently contacted the Minneapolis FSDO's to inquire about obtaining a replacement original airworthiness certificate, an external load and agriculture operating certificate. In a memo dated April 10, 2008, the Minneapolis FSDO informed Southern Region management that the owner of N5049F was seeking additional operating authority. Because of the pending SUPs investigation, the Minneapolis FSDO referred the certificate matters to the Southern Region for appropriate action. In a letter dated April 11, 2008, the Minneapolis FSDO informed N5049's owner that due to the ongoing SUPs investigation, he would have to contact Southern Region management to coordinate any matters related to the helicopter's airworthiness or operation.

The Southern Region SEIT manager acknowledged responsibility for handling the referral by the Minneapolis FSDO. In an attempt to assist N5049F's owner in resolving the issues with the helicopter's airworthiness, the manager called the owner three times, (April 16, 21, and 22, 2008) leaving messages. However, N5049F's owner never returned the manager's calls. On May 15, 2008, the helicopter was sold to a pilot in Michigan. On May 16, 2008, the new owner crashed the helicopter suffering fatal injuries.

FAA did not confirm the existence of unapproved parts in the FH-1100 fleet until October 30, 2008, when it issued an Unapproved Parts Notification applicable to the entire FH-1100 fleet.

ADDITIONAL INFORMATION

The SUPs criminal investigation remains open.

ATTACHMENT 1: METHODOLOGY OF INVESTIGATION

We reviewed numerous FAA records related to N5049F's maintenance, airworthiness, and registration history. These documents included internal memoranda, internal emails, accident photographs, personal handwritten notes, FAA accident-related records, and NTSB records and reports. We interviewed various FAA officials at the Grand Rapids and Minneapolis Flight Standards District Office, Great Lakes and Southern Region, Suspected Unapproved Parts Program, and attorneys from FAA Southern Region and Great Lakes Legal Division. These witnesses included:

- John Keller, former Aviation Safety Inspector, Grand Rapids, MI Flight Standards District Office (GR-FSDO)
- James Wilkinson, Front Line Manager, GR-FSDO
- Glenn White, Aviation Safety Inspector, FAA Southern Region
- Aris Scarla, Manager, GR-FSDO
- Ross Carroll, FAA Internal Safety Office
- Robert Turner, Manager, Minneapolis FSDO
- Tyrone Chatter, Branch Manager, FAA Security & Hazardous Materials, Great Lakes Region
- Rebecca Morris, Aviation Safety Inspector (Operations)
- Dennis Crawford, Aviation Safety Inspector (Maintenance)
- Richard Egan, Front Line Manager, Operations Minneapolis FSDO
- Barry Johnson, Aviation Safety Inspector (Maintenance)
- Augusto Casado, Executive Officer, Southern Region Flight Standards
- Thomas Winston, Acting Regional Division Manager, Great Lakes Region Flight Standards
- Kenneth Gardner, Suspected Unapproved Parts Program Coordinator, Flight Standards
- Virginia Costello, Senior Attorney, Great Lakes Region, Office of Regional Counsel
- Gayle Fuller, Senior Attorney, Southern Region, Office of Regional Counsel

ATTACHMENT 2: TIMELINE OF SIGNIFICANT EVENTS

Early/Mid-January 2008	Owner of N5049F contacts Minneapolis FSDO to obtain air tour operator Letter of Authorization
January 30-31, 2008	Southern Region Inspectors conduct re-examination of N5049F in Wisconsin
January 31, 2008	Airworthiness certificate (copy) of N5049F voluntarily surrendered by owner
February 19, 2008	Letter of Authorization for air tour operations utilizing N5049F issued by Minneapolis FSDO
February 20, 2008	Minneapolis FSDO learns of investigation by the Southern Region of N5049F
February 21, 2008	N5049F owner notified via e-mail by the Minneapolis FSDO that his helicopter is no longer airworthy
February 25, 2008	Southern Region issues a letter explaining the status of the investigation and N5049F's airworthiness
March 1, 2008	Owner of N5049 files a Customer Service Initiative complaint with FAA
March 2008	Southern Region receives an inquiry from Congressman Kind's office about the airworthiness certificate of N5043F
March 13, 2008	Southern Region returns the airworthiness certificates (copy) to owner of N5049F with a letter explaining the status of his helicopter and issues related to the certificate itself
April 10, 2008	Minneapolis FSDO informed Southern Region management that the owner of N5049F was seeking additional operating authority
April 11, 2008	Minneapolis FSDO sends letter to N5049's owner to contact Southern Region
April 16, 2008	Southern Region Manager calls owner to discuss options to ensuring the helicopter is airworthy, does not receive a return phone call from owner
April 21, 2008	Southern Region Manager calls N5049F owner, message left - no return call
April 22, 2008	Southern Region Manager calls N5049F owner, message left - no return call
May 15, 2008	N5049F sold
May 16, 2008	New owner/pilot crashed N5049F, suffered fatal injuries
May 16, 2008	Grand Rapids FSDO notified of accident beings on-site investigation with a team of inspectors, including the whistleblower
May 19, 2008	Whistleblower named FAA's IIC
June 2, 2008	Whistleblower removed from the accident investigation
October 30, 2008	FAA issued Unapproved Parts Notification on Fairchild-Hiller helicopter fleet
May 6, 2009	NTSB issues probable cause of accident: lack of fuel