

STATEMENT OF NICHOLAS A. SABATINI, ASSOCIATE ADMINISTRATOR FOR SAFETY, FEDERAL AVIATION ADMINISTRATION, BEFORE THE COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE, ON "CRITICAL LAPSES IN FAA SAFETY OVERSIGHT OF AIRLINES: ABUSES OF REGULATORY 'PARTNERSHIP PROGRAMS,'" APRIL 3, 2008

Chairman Oberstar, Congressman Mica, Members of the Committee:

I appreciate the opportunity to appear before you once again this morning. My name is Nick Sabatini and with me today are James J. Ballough, Director of Flight Standards Service here in Washington, and Thomas E. Stuckey, Manager of our Flight Standards Division in our Southwest Regional office. We have been asked to address the circumstances surrounding a specific incident involving the Federal Aviation Administration's (FAA) oversight of Southwest Airlines and whether that incident supports the contention that FAA's implementation and management of its voluntary disclosure programs, which the Committee refers to as regulatory partnership programs, are appropriate and in the best interest of aviation safety.

I will discuss the details of this incident later in my statement, but first, I think it is entirely appropriate to review these voluntary disclosure programs and evaluate how they have been administered, whether they have been effective, and if they should be modified. It is my hope that you will ultimately agree with me that the value of these programs should not be negated by an incident that all agree was extremely disturbing and not in accordance with the high standards of the FAA and my organization. My disappointment and regret over the FAA's failure to carry out its duties and responsibilities in this instance is beyond my ability to express and I do not minimize its importance. But I would hope that, after a balanced evaluation of all the available evidence, it can be put in a context where we in aviation learn from our mistakes and that the very real safety benefits of our programs are not jeopardized by an overly broad and possibly damaging reaction.

As many Members of this Committee will remember, it was not long ago when FAA's relationship with its stakeholders, including the airline industry, was extremely adversarial. Airlines warned their employees about cooperating with the FAA for fear of enforcement action against the individual or the airline. In that atmosphere, when an airline discovered that inadvertent mistakes had been made, they attempted to resolve the problems internally, without alerting the FAA. The value of this approach was limited. A specific problem was resolved at a specific facility. But the past practice of, in essence, keeping the problem a secret unless caught, did not permit the opportunity to put the problem in a broader context to determine whether a more comprehensive solution was necessary.

The trust that is necessary for voluntary disclosure programs to work did not come over night. There was certainly a period of adjustment for industry to believe that the FAA would not use their mistakes against them. In fact, there were adjustments to be made by everyone involved. FAA inspectors had to learn how to work with industry to raise the safety bar and how to enforce our safety standards when necessary. They had to understand that the value of being part of crafting the solution to a problem sometimes outweighed punitive action. But they also had to be able to identify those actions or violations that merited enforcement action, despite disclosure. Industry had to understand that what may appear to be an isolated event may have far broader implications, and that admitting the problem may mean finding a much more comprehensive solution, one benefitting an industry, rather than a facility. But, as with FAA inspectors, the industry needed to understand that disclosure was not a "get out of jail free" card. Certain types of violations would still result in punitive action. Therefore, fundamental to the success of all of the programs was a clear understanding of under what circumstances a reported violation could be processed through administrative action and under what circumstances legal enforcement action would apply. Each program has a specific process and checklist so that it is clear to all involved what type of action is acceptable for disclosure and what is not. What is clear, and what should have been clear to all of our inspectors, is that continued noncompliance after voluntary reporting is not permitted under any circumstances.

Our three major voluntary reporting programs gather information provided by certificate holders, individual employees of a regulated entity, and even the aircraft operating in the system. To illustrate how the programs work, the protections in place and the limited circumstances in which a disclosure may be accepted, I would like to briefly describe our primary disclosure programs.

The Voluntary Disclosure Reporting Program (VDRP) is intended to identify and correct adverse safety events that would otherwise not come to the FAA's attention. The qualifying VDRP disclosures and associated corrective actions are protected from both FAA formal enforcement action and public release. These protections allow FAA to oversee and participate in the root-cause analysis of events. VDRP requires FAA to review and approve all corrective actions, oversee the corrective actions and perform surveillance to assure the continued effectiveness of such actions. This process enables FAA to obtain and analyze important safety information of which the FAA might otherwise be unaware. FAA issued Advisory Circular AC 00.58A that provides clear guidance for submission of a disclosure of a safety problem to qualify for VDRP. There is also a VDRP website\*. It is FAA policy to accept a voluntary disclosure and forego legal enforcement action when ALL of the following criteria are met:

1. The certificate holder has notified FAA of the apparent violation immediately after detecting it and before the agency has learned of it by other means.
2. The apparent violation was inadvertent.
3. The apparent violation does not indicate a lack, or reasonable question of, qualification of the individual/entity.
4. Immediate action, satisfactory to the FAA, was taken upon discovery to terminate the conduct that resulted in the apparent violation.
5. The certificate holder has developed or is developing a comprehensive fix and schedule of implementation satisfactory to the FAA. The comprehensive fix must

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[http://rgl.faa.gov/Regulatory\\_and\\_Guidance\\_Library/rgAdvisoryCircular.nsf/0/85EB126D9DAF2461862571E800667468?OpenDocument](http://rgl.faa.gov/Regulatory_and_Guidance_Library/rgAdvisoryCircular.nsf/0/85EB126D9DAF2461862571E800667468?OpenDocument)

also include a follow-up self-audit to ensure that the action taken corrects the noncompliance. This self-audit is in addition to any audits conducted by the FAA.

Voluntary disclosures that meet these criteria are “closed” with an FAA administrative action (i.e. a Letter of Correction or a Warning Notice), meaning that no other regulatory enforcement action (e.g., civil penalty, or certificate suspension or revocation) is taken.

The Aviation Safety Action Program (ASAP) is another voluntary reporting program that is also designed to identify and correct adverse safety events reported by an employee of a regulated entity (e.g., an airline or maintenance facility) that would otherwise not be likely to come to the attention of FAA or company management. The objective of the ASAP program is to encourage air carrier and repair station employees to voluntarily report safety information that may be important to identifying potential precursors to accidents. This program enables participants to identify actual or potential risks. An ASAP program is tailored to one entity (air carrier, repair station) and is entered into voluntarily by the FAA, the certificate holding entity (i.e., Part 121, 135 or 145 certificate holder), and any applicable third party, such as the employee’s union. A key part of the program is that it is overseen by a two or three member panel, known as an Event Review Committee (ERC), made up of designated representatives from the FAA, the certificated entity and usually a representative for the employees union or organization.

The main responsibilities of the ERC are to review and analyze reports submitted under ASAP, determine whether such reports qualify for inclusion, identify actual or potential safety problems, and propose solutions for the problems. ASAP is implemented in accordance with a Memorandum of Understanding (MOU) that provides the specifics of each program. FAA guidance on how to draft an acceptable MOU are found in FAA Advisory Circular AC 120-66B and on an ASAP website\* .

Where an employee is the sole source of a disclosure regarding a possible safety violation that qualifies pursuant to the MOU, it is FAA policy not to use the content of any such

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\* [http://www.faa.gov/safety/programs\\_initiatives/aircraft\\_aviation/asap/](http://www.faa.gov/safety/programs_initiatives/aircraft_aviation/asap/)

ASAP report to initiate or support any legal enforcement action against such employee. Similarly, the certificate holder will not use the information in a report submitted under ASAP to initiate or support any company disciplinary action. Where the employee is not the sole source of information, but the information is still accepted under ASAP, the FAA will take administrative action instead of legal enforcement action, even when sufficient evidence exists to support a violation. Administrative action means an FAA Warning Notice or Letter of Correction, which is expunged from FAA's files after two years. Where the employee is not the sole source of the information and the information is insufficient to prove a violation, the FAA will issue a Letter of No Action, which is expunged from FAA's files after 30 days.

To be accepted, an ASAP report must be submitted in a timely manner, usually within 24 hours of the employee's having become aware of the possible noncompliance with the Federal Aviation Regulations. The alleged regulatory violation must be inadvertent, and must not appear to involve intentional disregard for safety. In addition, the reported event cannot be accepted if it appears to involve criminal activity, substance abuse, controlled substances, alcohol, or intentional falsification. The ERC determines the disposition of all ASAP reports through consensus, including the corrective action for accepted reports, if determined to be appropriate.

As of February 2008, over 70 operators are participating in ASAP, and over 170 MOUs have been established for different employee groups (pilots, dispatchers, mechanics and flight attendants).

One final voluntary reporting program with which the Committee may be aware is the Flight Operational Quality Assurance (FOQA) program. FOQA is a voluntary airline program for the routine collection and analysis of digital flight data generated during line operations. Although it enables monitoring of individual aircraft operations and system performance, its principal value is in providing objective information on adverse safety trends obtained by aggregating data from multiple flights. Acquisition of such aggregate data can provide an unprecedented basis for proactive intervention to correct unsafe

trends before they can lead to accidents. Today's FOQA program is the result of a successful Demonstration Project initiated in 1995 that enabled FAA to both establish the usefulness of the information and gain the insight needed to establish a regulatory framework for the program.

The FOQA regulation, finalized in 2001, codifies protection from the use of data from FAA approved FOQA programs for enforcement purposes, except for criminal or deliberate acts. No airline is required to have a FOQA program, nor is it required to obtain FAA approval of its program. However, an airline that seeks the enforcement protection of the rule must obtain FAA program approval through the formal approval of the Implementation and Operations Plan. FOQA also requires participating airlines (there were 20 as of February 2008) to inform the FAA of adverse safety trends revealed by their programs, as well as corrective action undertaken.

The FAA conducts periodic FOQA Information Sharing Meetings with industry to identify and discuss safety issues of potential national significance. Issues identified from such meetings serve as a source for follow-on study. Additionally, broad systemic issues identified through the Information Sharing Meetings lead to corrective actions that benefit not only one program owner but the industry as a whole. One such example is a change to an air traffic procedure to enhance safety.

In an industry with an excellent safety record, finding ways to improve safety is always a challenge. But it is a challenge that we embrace and in the last decade, many of the safety improvements we have made are the direct result of information we received through these voluntary disclosure programs; information that industry and its employees would not have provided to us just a few years ago. While it is entirely appropriate to review the guidelines and procedures implementing these programs to determine whether they remain valid, I urge you to recognize the ongoing importance of these programs for providing us with access to important safety information to identify and address safety problems before they manifest themselves in an accident.

As a result of the information we have obtained through voluntary disclosure programs, we have implemented safety enhancements in deicing programs, airport signage, air traffic procedures, and maintenance procedures. For example, there have been instances when a carrier or individual employees of the carrier identified and corrected improperly installed equipment. By sharing the data we were able to improve and clarify information provided to mechanics so a similar mistake would not occur at other carriers. The vast amount of information we receive through the voluntary reporting programs is invaluable and while I support a dialogue to ensure appropriate and consistent implementation of the programs, I truly believe a disruption of these programs will negatively impact safety.

I will turn now to the completely unacceptable situation that occurred last year involving Southwest Airlines and FAA's oversight of their operations. FAA has fully cooperated with the ongoing investigations of this incident with the Inspector General and the Special Counsel. I will not restate the facts of the situation here, as the basic facts are not in dispute. The bottom line is that the FAA Principal Maintenance Inspector (PMI), who was charged with overseeing Southwest Airlines, inappropriately and in violation of existing FAA policy and regulatory requirements, accepted a voluntary disclosure under the VDRP program. The disclosure was the fact that 46 Southwest Airlines aircraft had continued flight operations past the due date for a required inspection of the aircraft airframe for cracks. These aircraft had overflown an Airworthiness Directive (AD) requiring the inspection.

Despite this determination, and, again, in violation of existing FAA policy and regulatory requirements, the airline, even after reporting this safety violation under VDRP, did not ground these aircraft immediately but instead continued to operate the aircraft. To be clear, no FAA inspector has the authority to permit continued non-compliance of aircraft operations. In fact, the VDRP requires a confirmation that the non-compliance has ceased in order for the VDRP to be accepted. Subsequently, the airline conducted the required inspections and six aircraft were discovered to have cracks, five of which were ultimately determined to have the type of crack the AD was designed to detect. A total of

1451 commercial operations were conducted by Southwest Airlines in violation of the law, putting thousands of passengers at risk. That this was done with the implicit consent of the FAA PMI overseeing the carrier is beyond my comprehension. I am also disturbed that, while the office manager began a review of this situation and asked for support from our Southwest Region Flight Standards Office (Region), it was not fully investigated until one of my front-line safety inspectors reported it to the Administrator's hotline and DOT IG hotline.

On March 6, 2008, the FAA issued a \$10.2 million proposed civil penalty to Southwest Airlines for its decision to knowingly continue to fly noncompliant aircraft in commercial operations. This decision was inexcusable and put its passengers at risk. The FAA PMI who accepted the VDRP in violation of existing FAA standards and policies and who essentially permitted the unsafe flights to continue has been reassigned, is no longer supervising inspectors, and is the subject of a pending personnel action. The action has not been finalized to date because the IG investigation is ongoing and we are waiting to consider all evidence before taking final action.

I cannot overstate my disappointment and, frankly, outrage and shock at the actions of Southwest Airlines and the FAA PMI. I will not attempt to condone either. Every FAA safety official must be dedicated to ensuring that we have the safest aviation system in the world. Every FAA safety official must be dedicated to finding new ways to improve a system that has an already enviable safety record. To learn that this was not the case with respect to certain individuals at the Certificate Management Office (CMO) overseeing Southwest Airlines is beyond troubling. I applaud the persistence, dedication, and tenacity of FAA inspector Bobby Boutris in pursuing the identified deficiencies at Southwest Airlines, in spite of the unacceptable and inappropriate obstacles he faced due to the working environment at our CMO and the actions of his supervisor, the PMI. Frankly, it is the reaction I would hope all of my inspectors would have to a similar situation.

Let me state first that this is my workforce. I am ultimately responsible for their actions. I am here today to apologize to this Committee and, more importantly, to the travelling public for FAA's failures in this situation. We have taken this situation extremely seriously and have done a great deal of soul searching and analysis to determine how the problems developed, how FAA could have prevented them and, most crucial at this point, how we proceed from here.

FAA's inspector workforce is made up of 3859 individuals. It is impossible to expect in a workforce of this size and scope that there will not be instances of personality clashes or professional disagreements. Often, honest disagreements result in debate that is both healthy and productive if it is approached with respect and professionalism. It is a critical management challenge to understand when personality differences and reports of inadequate or nonconforming oversight rises to the level of requiring regional or headquarters intervention.

In the situation at hand, we now see that the management and interpersonal problems that existed in the CMO where the PMI overseeing Southwest Airlines worked contributed to the incident. Managers in the Southwest Region's Flight Standards office did counsel both the manager of the CMO\* and the PMI, about reports of their inability to work cooperatively with each other in early 2006. Follow-ups to this counseling did occur. Both managers claimed the counseling had improved the situation. An FAA Work Environment Assessment Team, known as a "WEAT" was dispatched by the Southwest Region Flight Standards Office to the CMO for onsite evaluation. The team concluded that a "tense relationship" existed between the manager of the CMO and the PMI. The WEAT recommended that these individuals be put on notice that the conflicts in the workplace were unacceptable and would not be tolerated. The team further recommended that the office's management team participate in team building exercises facilitated by a regional representative. In addition, the manager of the CMO was

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\* There are 19 certificate management offices (CMOs) under the FAA's Southwest Region Flight Standards office supervision

directed to develop an action plan to address the WEAT findings. All the WEAT findings were addressed and the action plan completed by the end of 2006.

In fact, we now know that the actions taken did not result in an improvement in relations between the key individuals, despite their reports to the contrary. Things continued to spiral downward, culminating in the CMO personnel communicating, in part, through hotline complaints beginning in early 2007. This is ultimately how Mr. Boutris reported the improper acceptance of the voluntary disclosure of the noncompliance with the AD. In retrospect, it is clear that the dysfunctional relationship between the manager of the CMO and the PMI was sadly emblematic of dysfunction throughout the office. It thwarted the sort of open communication that should have prevented the continued operation of noncompliant aircraft. It set up the office to support either the PMI or the manager of the CMO. That such dysfunction should pose a threat to safety is unacceptable.

Although we all understand it is impossible to change the past, it is vitally important that we learn from it. Our analysis suggests that more effective intervention in late 2005 and 2006 was FAA's best opportunity to effect a change in the outcome of the events in March of 2007. Despite the assertions of the manager of the CMO and the PMI that the interventions of regional counseling and the WEAT were effective and that their interpersonal disagreements were reconciled, we now acknowledge that we should not have accepted these assertions at face value. The concerns of the workforce that, absent an ongoing regional presence, the cosmetic reconciliation would be revealed for what it was – a pretense – was an alarm bell that should have been listened to. Likewise, there should have been more visits by the Division Management Team (DMT) from the Southwest Region to the CMO, including conversations with front line inspectors asking for their view of how the office was functioning. This did not happen. The focus on the differences between the manager of the CMO and the PMI by the Region ignored the valuable information the frontline inspectors had to provide. The Region also did not recognize that the disputes they were aware of posed a risk to safety.

In a properly functioning CMO, if a voluntary disclosure was improperly accepted, there would have been dialogue, debate and, if necessary, elevation of the issue to the region or headquarters. Had this happened, the aircraft would have been grounded and the noncompliance would have been prevented before posing a threat to the flying public. Unfortunately, this did not occur at this facility. The Region became aware of this only after the office manager questioned the validity of the VDRP. The Region then began an investigation into the circumstances of the case. Mr. Boutris alerted the office manager who in turn alerted regional personnel later that month regarding other significant safety issues.

The investigation of the events surrounding this incident is ongoing, but it is clear FAA's failure to prevent Southwest from operating 1451 noncompliant operations was the result of a complete breakdown in adherence to FAA's procedures and policies. We are taking steps throughout the organization to emphasize to our workforce the need for managers to provide their inspectors with a forum to discuss professional disagreements. We want all of our inspectors to understand and appreciate their responsibility to make their concerns known and elevate them if they are not satisfied with their supervisors' reaction.

As I told this Committee, ultimately I am responsible for my workforce's actions, and I am personally taking steps to ensure that something of this nature does not happen again. In fact, on March 11, 2008, we held a Managers Conference with 88 of the AVS organizations top leaders, at which Acting Administrator Sturgell and I emphasized to our managers that our commitment to safety is paramount, that we need to fight against complacency, and that our policies and procedures must be followed to ensure the appropriate checks and balances to protect the traveling public.

Additionally, we communicated to the entire work force through a Town Hall meeting held on March 18, 2008 the importance of open dialogue and communication. I made it clear that I encourage this workforce to voice their opinions and concerns, and I wanted them to know that when they do so, they can be assured that their concerns will be welcomed in a culture that will not and does not tolerate repercussions. To support my

commitment in this area, I have ordered the development of a Safety Issues Reporting System that will afford employees with the opportunity to report safety concerns.

I fully appreciate the significance of this incident, but to use this to make broad assumptions about the overall state of FAA's oversight or the safety of the industry as a whole would be a mistake. The safety record simply does not support allegations that the system and FAA are broken. That having been said, we are always open to working with industry and Congress to discuss ways to make our safe system even safer and I would hope that is what we can do here today.

Mr. Chairman, that completes my prepared statement. Mr. Ballough, Mr. Stuckey, and I would be happy to answer any questions you and the Members may have.