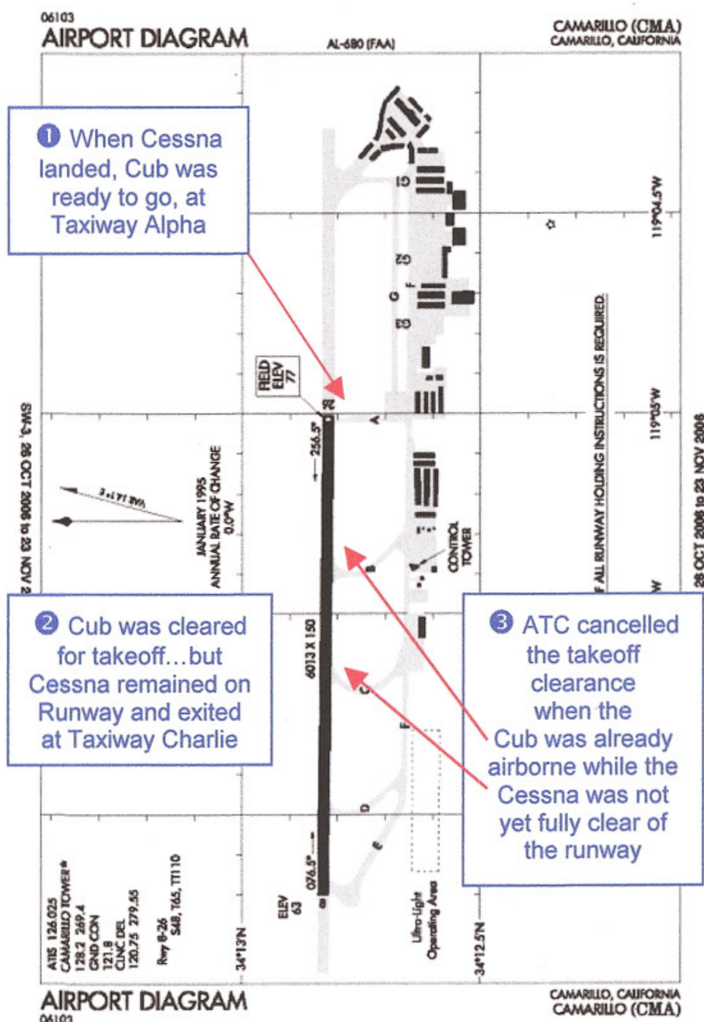
An Unsafe Incident at Camarillo:

Separation was lost, but not reported … and FAA officials continue to conceal the incident.



A fundamental rule in air traffic control is that the controller must ensure no other aircraft is on the same runway, before he or she issues a takeoff clearance. Despite this intent, mistakes do happen, which are considered a 'traffic conflict', and formally labelled an Operational Error (or, OE).

Consistent with FAA's role and responsibilities, FAA personnel are required to immediately report all OE's. Those OE's are then immediately and fully investigated, to prevent their recurrence. This is how FAA's Safety Culture is supposed to work. In reality, sometimes it fails.

An example: the details of the Operational Error that occurred at Camarillo, CA on 7/25/10. Two aircraft were involved: Cessna N6606Y and Cub N33112. The Cessna had landed, and the controller cleared the Cub to takeoff. The controller failed to notice that the Cessna was still on the runway. Twenty seconds later, the Cub became airborne while the Cessna had not yet exited the runway.

Official records show there were three ATC personnel working in the tower: the local controller, the ground controller, and a supervisor. All three recognized the conflict at about the time the Cub became airborne. The local controller reactively cancelled the Cub's takeoff clearance. The Cub pilot likely saw that an immediate cancellation would force her to descend toward the Cessna, so she stayed airborne and asked the controller to repeat. The ground controller and the supervisor commented that a takeoff cancellation was a bad idea. So, the local controller told the Cub to disregard the cancellation. The controller then told the Cessna to exit the runway at taxiway Charlie.

Here are key transcript elements, as produced from the actual ATC tapes:

At 9:54 (minutes/seconds), ATC said: *"November one one two, right turn runway two six, cleared for takeoff."*

9:58, N33112: *"two six cleared for takeoff one one two."*

10:18, ATC: *"Cub one one two, cancel takeoff clearance."*

10:22, N33112: *"one one two (pause) repeat?"*

10:25, ATC: *"one one two, disregard."*

10:28, ATC: *"november zero six yankee, turn left at Charlie, contact ground point eight."*

Normally, this sort of OE would precipitate a quick investigation and report. In this situation, though, the supervisor chose to do nothing. Consequently, no controller statements were collected, no Incident Reports were compiled and shared with the Regional QA officials, and nothing was done to prevent a recurrence. This was an unsafe Operational Error, which the CMA FAA Management chose to ignore.

The details of this unsafe incident were preserved by a whistleblower controller. He was concerned that the incident was being *'swept under the rug'*, so he made a FOIA request for the ATC tapes. He elevated his concerns to FAA officials at the Regional and Headquarters levels. After persisting for eleven months, the whistleblower was able to get FAA's AOV office to investigate. When interviewed in June 2011, the ground controller reported a clear OE, fully consistent with the ATC tapes. Meanwhile, the local controller and supervisor both had 'no memory' of an incident they needed to forget. Higher FAA officials concluded that the tape was *'inconclusive'*.

What do you think?

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