National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: July 6, 2004

In reply refer to: H-04-18 through -20

Honorable Annette M. Sandburg
Administrator
Federal Motor Carrier Safety Administration
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At 2:56 p.m. on June 23, 2002, a 1998 Motor Coach Industries, 55-passenger motorcoach, operated by Arrow Line, Inc., (Arrow) a Coach USA subsidiary, was traveling eastbound between 60 and 63 mph on Interstate 90 near Victor, New York.[1] The motorcoach, carrying 47 passengers, was en route from Niagara Falls, Ontario, Canada, to Waterbury, Connecticut. As the bus approached the Victor Exit 45 ramp, the vehicle departed the roadway and proceeded into the depressed grassy area between the eastbound exit and entrance ramps. The motorcoach then struck a W-beam guardrail, dragged approximately 700 feet of the guardrail across the eastbound entrance ramp, vaulted over the entrance ramp roadway, landed on the south side shoulder of the entrance ramp, rolled 90 degrees onto its right side, and slid to rest. The guardrail dragged by the motorcoach during the accident sequence then struck three eastbound vehicles on the entrance ramp. Three occupants of these vehicles were uninjured, and six received minor injuries. Of the 48 people on the motorcoach, 5 passengers were killed; the driver and 41 passengers sustained injuries; and 1 passenger was uninjured.

The National Transportation Safety Board determined that the probable cause of the accident was that the bus driver fell asleep while operating the motorcoach due to his deliberate failure to obtain adequate rest during his off-duty hours. Contributing to the cause of the accident was the second Arrow Line, Inc., motorcoach driver, who did nothing to prevent the severely fatigued driver from operating the accident motorcoach, and the failure of Arrow Line, Inc., and its holding company, Coach USA, to provide adequate oversight of their drivers. Contributing to the severity of the accident was the lack of occupant restraints for the motorcoach passengers.

About 11:00 p.m. on Thursday, June 20, 2002, the accident bus departed Waterbury and a second chartered bus (motorcoach 2) departed Manhattan for a trip to Niagara Falls sponsored by a Waterbury church. The accident motorcoach met motorcoach 2 at the Canadian border, and both proceeded to a Niagara Falls hotel. The accident bus driver told the New York State Police

[1] For additional information, read National Transportation Safety Board, *Motorcoach Run-off-the-Road and Rollover off Interstate 90 Near Victor, New York, on June 23, 2002*, Highway Accident Report NTSB/HAR-04/03 (Washington, DC: NTSB, 2004).

(NYSP) that he arrived at the hotel about 7:30 a.m. on Friday, June 21, 2002. The group organizers scheduled both motorcoaches to visit Marineland on Saturday, June 22, 2002. The motorcoach operators had no other scheduled driving duties until the return trip on Sunday, June 23, 2002.

The motorcoach 2 driver told the NYSP that he spoke with the accident bus driver on Saturday morning, when the accident driver stopped by his hotel room and said that he had won $4,000 at the casinos. According to the motorcoach 2 driver's statements, he knew that the accident driver slept for about 3 hours in the bus while the tour group was at Marineland, and he observed the accident driver getting into a cab to go to the casino about 5:00 p.m. on Saturday.

The accident driver informed the NYSP that he had been at the casino from noon on Friday until about 10:00 a.m. on Saturday, when he went back to his hotel room but did not sleep. Both motorcoaches departed the hotel about noon on Saturday and transported passengers to Marineland. The accident bus driver said that he remained with his motorcoach, napped about 3 hours, and left for the hotel with his passengers about 4:00 p.m. According to the accident bus driver, he showered at the hotel and then left for the casinos, where he remained until approximately 9:00 a.m. on Sunday morning.

About 8:30 a.m. on Sunday, June 23, the motorcoach 2 driver prepared his vehicle for the return trip boarding. According to the group organizers, when, at their request, hotel staff attempted to summon the accident bus driver from his room around 9:30 a.m., the accident bus driver did not answer. The motorcoach 2 driver told the NYSP that he saw the accident bus driver arrive at the hotel about 9:30 a.m., and the accident bus driver said that he had lost the money overnight that he had won the previous evening. The accident bus driver showed up at his motorcoach shortly before 11:00 a.m. (the scheduled departure time), opened the luggage compartment, took his seat behind the wheel, and slept while passengers loaded their luggage onto the motorcoach. Because one group organizer expressed her concern to the motorcoach 2 driver that the accident bus driver did not appear fit to drive, he roused the accident bus driver and asked whether he was all right to drive. The accident bus driver replied, "Yes, I'm fine." The motorcoach 2 driver planned to return directly to Manhattan; the accident bus driver planned to stop at two or three attractions before returning to Waterbury. The two motorcoaches departed about 12:30 p.m.

The trip coordinators and several motorcoach passengers expressed concern over the accident bus driver's visible sleepiness. Even without knowing that the driver had been awake for nearly 2 days, the coordinators recognized that the driver was unfit to perform his duties, since he displayed obvious signs of a sleep-deprived state. Initially, they sought the assistance of the motorcoach 2 driver, who knew of the accident driver's overnight casino trips and yet deferred to the accident driver's statement that he was "okay to drive." The motorcoach 2 driver told the NYSP that the accident bus driver had "30 years experience and would know if he was alright." During the trip, a coordinator used the microphone, speaking in Spanish, to tell the passengers that they should make noise because the driver was sleepy. Another passenger approached the driver just prior to Victor Exit 45 and asked him to pull over at the next stop and rest; however, the driver rebuffed her and she started to return to her seat.

During interviews, the passengers indicated obvious concern regarding the driver's state; yet, either the passengers did not recognize the seriousness of the situation, or none were able to identify an option to promptly obtain the driver's cooperation in delaying or discontinuing the trip until he had obtained sufficient rest. After having approached the accident bus driver's

colleague and after futilely requesting his assistance with the fatigued driver, several passengers felt helpless during the events that led up to the accident and seemed reluctant or felt unable to take control of the increasingly dangerous situation. Although many passengers aboard the motorcoach used their cellular telephones to call relatives and friends after the accident, none used the cellular telephones before the accident to report the driver or situation to 9-1-1. Instead, the passengers deferred to the driver's authority and let the trip continue.

In a motorcoach, the driver is normally in charge, which in most situations is the most appropriate allocation of authority. When a driver is impaired, whether due to fatigue, intoxication, or an apparent medical condition, passengers are placed at risk. But individuals may be reluctant to challenge a driver's fitness for duty directly, particularly if the driver is irritable or defensive or simply refuses to postpone the trip or to pull over. In this accident, passengers approached the motorcoach 2 driver, asked for his assistance, and subsequently deferred to his opinion that the accident driver was fit to operate the motorcoach.

Although the exterior of the accident motorcoach displayed an emergency number, no similar posting was available inside the bus for passengers to use when they observed the bus driver operating the motorcoach in an unsafe manner. An emergency number posted inside the motorcoach may have prompted the passengers to call and report the bus driver's behavior. The Safety Board concluded that had Arrow provided a method for passengers to contact the company to report the driver's severely fatigued condition, the company could have prevented the driver from beginning or continuing the accident trip. Emergency situations can occur at any time and on any passenger carrier's motorcoach. Therefore, the Safety Board believes that the Federal Motor Carrier Safety Administration (FMCSA) should require the posting of an emergency telephone number on the interior of motorcoaches for passengers to call in the event of an emergency with the driver.

On February 6, 1986, the Bureau of Motor Carriers (predecessor agency to the FMCSA) and the U.S. Department of Defense (DoD) Military Traffic Management Command (MTMC) (predecessor agency to the Surface Deployment and Distribution Command [SDDC]) signed a Memorandum of Agreement that provided information and granted the MTMC access to the Motor Carrier Management Information System, which contains a carrier's profile, accident history, enforcement inspection history, and compliance review and safety rating information. Arrow underwent inspections by the DoD's contractor in 1998, 1999, 2000, and 2001. The most recent inspection was on December 4, 2001, and resulted in a low rating of 4. The executive summary of the inspection report noted a number of serious violations and operational deficiencies. Neither the DoD contractor nor the MTMC office contacted the FMCSA to report its findings, nor were they required to do so.

Many of the deficiencies noted in the MTMC 2001 inspection were the same violations listed in the FMCSA's postaccident compliance review of Arrow and included violations in vehicle maintenance, driver qualifications, and driver records. Both the FMCSA in 1994 and MTMC in previous inspections had identified these same deficiencies on the part of Arrow. According to the FMCSA, one mechanism that can trigger a compliance review is a complaint against a company. Had the MTMC information been shared with the FMCSA, it may have caused the FMCSA to conduct a compliance review of Arrow before the accident. Additionally, in response to the FMCSA's postaccident compliance review, Arrow made changes, such as replacing management and supervisory personnel, in an attempt to correct violations of the *Federal Motor Carrier Safety Regulations*. The Safety Board concluded that although the

FMCSA had not prioritized Arrow for a compliance review from 1994 until the accident, the agency might have done so had the MTMC alerted the FMCSA to Arrow's unsafe, repetitive practices discovered during its inspection. The Safety Board believes that the SDDC (formerly known as the MTMC) should provide motor carrier information, including timely results of passenger carrier inspection processes and ratings, to the FMCSA. Such an exchange would provide the FMCSA with an additional opportunity to identify potentially unsafe motor carriers and schedule compliance reviews. The Safety Board believes that the FMCSA should utilize motor carrier safety information, including results of compliance audit reports provided by the SDDC, to determine whether further review of a motor carrier is warranted.

The FMCSA utilizes the Safety Status Measurement System (SafeStat) to identify and prioritize carriers for FMCSA safety improvement programs, such as roadside inspections and compliance reviews. The SafeStat selection system is based on a carrier's history of previous roadside inspections, accidents, enforcement actions, and safety. The carrier's Safety Evaluation Area value approximates the carrier's percentile rank relative to all other carriers with sufficient data to be assessed within the same Safety Evaluation Area.

The SafeStat system ranks all motor carriers in relation to each other. But ranking passenger motor carriers in relation to nonpassenger carriers does not effectively draw attention to passenger carriers that should be considered high-risk. As of February 20, 2004, over 678,000 recorded motor carriers with census data in SafeStat were actively operating in interstate commerce. Of those, only 30,000 were passenger carriers. Therefore, not only are passenger carriers underrepresented in the larger motor carrier population, they are also underrepresented in SafeStat rankings. As a result, a passenger carrier that ranks poorly compared with other passenger carriers, may not rank poorly when compared to the larger population of motor carriers.

Because motorcoaches carry a large number of passengers who rely on the safety assessment of a given carrier in making transportation decisions, it is critical that passenger carriers be evaluated separately from the truck population. If passenger carriers were to be rated and evaluated only in relation to other passenger carriers, the resulting safety information would be more valid and would accurately highlight and prioritize unsafe carriers for the public using the Internet database, as well as for the FMCSA in compliance reviews or roadside inspections.

As a result of the Victor accident investigation, the Safety Board concluded that due to its composite ranking methodology, the current SafeStat program does not accurately reflect the safety fitness of motorcoach operators. The Safety Board believes that the FMCSA should revise SafeStat to compare passenger carriers to other passenger carriers to ensure accurate safety ratings.

Therefore, the National Transportation Safety Board recommends that the Federal Motor Carrier Safety Administration:

> Require the posting of an emergency telephone number on the interior of motorcoaches for passengers to call in the event of an emergency with the driver. (H-04-18)
>
> Revise the Safety Status Measurement System to compare passenger carriers to other passenger carriers to ensure accurate safety ratings. (H-04-19)

Utilize motor carrier safety information, including results of compliance audit reports provided by the U.S. Department of Defense Surface Deployment and Distribution Command, to determine whether further review of a motor carrier is warranted. (H-04-20)

The Safety Board also issued safety recommendations to the U.S. Department of Defense Surface Deployment and Distribution Command and Coach USA In addition, the Board reiterated two recommendations to the National Highway Traffic Safety Administration.

Please refer to Safety Recommendations H-04-18 through -20 in your reply. If you need additional information, you may call (202) 314-6177.

Chairman ENGLEMAN CONNERS, Vice Chairman ROSENKER, and Members CARMODY, HEALING, and HERSMAN concurred in these recommendations.

Original Signed

By: Ellen Engleman Conners
Chairman