National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: July, 6, 2004

In reply refer to: H-04-21

Major General Ann E. Dunwoody
Commanding General
U.S. Department of Defense
Surface Deployment and Distribution Command
Hoffman Building II SDPP-IP
200 Stovall Street, Room 10S67
Alexandria, Virginia 22332-5000

The National Transportation Safety Board is an independent Federal agency charged by Congress with investigating transportation accidents, determining their probable cause, and making recommendations to prevent similar accidents from occurring. We are providing the following information to urge your agency to take action on the safety recommendation in this letter. The Safety Board is vitally interested in this recommendation because it is designed to prevent accidents and save lives.

This recommendation addresses the effective identification and prevention of unsafe passenger carrier operations. The recommendation is derived from the Safety Board's investigation of the June 23, 2002, motorcoach run-off-the-road and rollover accident off Interstate 90 near Victor, New York,[1] and is consistent with the evidence we found and the analysis we performed. As a result of this investigation, the Safety Board has reiterated two and issued five new safety recommendations, one of which is addressed to the U.S. Department of Defense Surface Deployment and Distribution Command. Information supporting this recommendation is discussed below. The Safety Board would appreciate a response from you within 90 days addressing the actions you have taken or intend to take to implement our recommendation.

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. 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

[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).

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.

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 (NYSP) that he arrived at the hotel about 7:30 a.m. on Friday, June 21, 2002. On Sunday, June 23, 2002, the two motorcoaches departed Niagara Falls about 12:30 p.m. 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 accident driver informed the NYSP that he had been at a 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.

During the return trip, a coordinator on the accident bus used the microphone, speaking in Spanish, to tell the passengers that they should make noise because the accident driver was sleepy. Another passenger approached the accident driver just prior to Victor Exit 45 and asked him to pull over at the next stop and rest; however, the accident driver rebuffed her.

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.

According to the Federal Motor Carrier Safety Administration (FMCSA) registration, Arrow was an authorized for-hire passenger motor carrier headquartered in East Hartford, Connecticut. At the time of the accident, Arrow provided charter service and tour service throughout the United States and Canada.

Before the accident, according to the U.S. Department of Defense (DoD) Military Traffic Management Command (MTMC) (predecessor agency to the Surface Deployment and Distribution Command), Arrow underwent inspections by the DoD's contractor in 1998, 1999, 2000, and 2001. The most recent inspection was on December 21, 2001, and resulted in a low rating. In the 2001 MTMC compliance audit report of Arrow, a number of "serious violations and operational deficiencies [were] found during the review" and "significant breakdown in the carrier's safety management controls" was revealed. The audit report also noted:

> Whenever an audit is conducted, if violations and operational deficiencies are brought to the carrier's attention, it is expected that they will take decisive and immediate corrective action to prevent future violations. When similar violations or operational deficiencies are again found during any subsequent audits, it has the appearance that the carrier has either chosen to ignore the violations or failed to take any initiative to address the concerns.

Many of the deficiencies noted in the MTMC 2001 inspection were the same violations listed in the 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. However, neither the DoD contractor nor the MTMC office contacted the FMCSA to report its findings in the 2001 compliance audit report, nor were they required to do so. 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. 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. Such an exchange would provide the FMCSA with an additional opportunity to identify potentially unsafe motor carriers and schedule compliance reviews.

Therefore, the National Transportation Safety Board recommends that the U.S. Department of Defense Surface Deployment and Distribution Command:

> Provide motor carrier information, including timely results of passenger carrier inspection processes and ratings, to the Federal Motor Carrier Safety Administration. (H-04-21)

The Safety Board also issued safety recommendations to the Federal Motor Carrier Safety Administration and Coach USA and its subsidiaries. The Board also reiterated safety recommendations to the National Highway Traffic Safety Administration. In your response to the recommendation in this letter, please refer to H-04-21. 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 this recommendation.

By: Ellen Engleman Conners
Chairman