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Log H-563

National Transportation Safety Board

Washington, D. C. 20594

Safety Recommendation

Date: April 1, 1992

In Reply Refer To: H-92-13 through -17

Mr. Frank Schmeider
President and Chief Executive Officer
Greyhound Lines, Inc.
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On June 26, 1991, about 1:50 p.m., a Greyhound bus traveling from Cleveland, Ohio, to Washington, D.C., ran off the right side of the roadway and overturned on the Pennsylvania Turnpike near Donegal, Pennsylvania. One passenger was fatally injured, the driver and 14 passengers were injured, and 1 passenger was uninjured.

On August 3, 1991, about 6:45 a.m., a Greyhound bus traveling from New York City to Buffalo, New York, ran off the right side of the roadway, and overturned on State Route 79 near Caroline, New York. The driver and 33 passengers were injured, and 5 passengers were uninjured.[1]

The Safety Board's investigation of these accidents focused on the adequacy of driver training and experience, including behind-the-wheel training and cubbing, and also addressed driver route familiarity and rest.

The two busdrivers involved in these accidents had very little experience driving any type of vehicle. Their Pro Drive training scores and comments from the instructors indicated they both initially performed poorly in the driving skills portions of school. Both drivers were near the bottom of their class when they graduated.

The Caroline busdriver began driving as soon as he graduated because he was not required to obtain a CDL in Washington, D.C. The Donegal busdriver had to pass the CDL tests to obtain a license to drive. She failed: (1) the General Knowledge Test once, (2) the Passenger Transport test once, (3) the Air Brakes Test twice, and (4) the

[1]For more detailed information, read Highway Accident Report--*Greyhound Bus Run-Off-The-Road Accidents: Donegal, Pennsylvania, June 26, 1991, and Caroline, New York, August 3, 1991* (NTSB/HAR-92/01).

road test once. Thus, she failed CDL series tests five times in 1 week. When she finally passed the Air Brakes test, she received a minimally passing score.

Refresher reports at the Donegal busdriver's home terminal indicated that she needed more practice. The driver instructor also commented that she was "nervous" while driving and that she performed "pretty good with instruction."

The Safety Board believes that Greyhound had sufficient warning that the Donegal busdriver was unprepared to independently operate an intercity bus. Although indications were not as clear regarding the Caroline driver's abilities, the Safety Board concludes that if Greyhound had a program in place that identified drivers in need of more behind-the-wheel training, and then provided this training, both busdrivers may have been better prepared to operate their buses.

The Greyhound Safety Director indicated that cubbing is an extension of behind-the-wheel training. However, Greyhound terminal managers apparently did not view the cubbing process as behind-the-wheel training. They described it as an exercise strictly to learn the routes and the routine of handling passengers and baggage. The Safety Board concludes that although it may have been Greyhound's policy to use cubbing as additional behind-the-wheel training, the policy was not instituted at the accident drivers' terminals.

With respect to the issue of route familiarity, both busdrivers were traveling the accident routes for the first time, and both had expressed concern about their unfamiliarity with the routes. In the Donegal accident, the busdriver's difficulties with the route directions may have caused some stress. She stated that she was nervous when assigned to drive a bus to Washington, D.C., because she had never driven there before. Greyhound provided her with written directions and diagrams; however, some of them were incorrect and unclear, and she got lost several times and had to turn around and double back to correct her mistakes. The Caroline busdriver acknowledged that he was unfamiliar with his route, and as a result, attempted throughout the trip to maintain about one car length between his bus and the lead bus to prevent other vehicles from getting between the buses. This was confirmed by one of the bus passengers, who told investigators that the driver would speed up occasionally to keep up with the lead bus. Therefore, the Safety Board concludes that the unfamiliarity with the accident routes increased both busdrivers' stress during the accident trips, adversely affecting their performance.

With respect to the issue of rest, the Safety Board found that prior to each accident, the drivers had received limited rest. The Donegal busdriver had been on duty for 11 hours and had been driving for 5 1/2 hours. She had taken a 3-hour nap on the afternoon before the accident, slept for 4 hours (9 p.m. to 1 a.m.) before coming on duty, and napped for 1 1/2 hours before actually driving. The last time the Donegal busdriver had eaten was 12 hours prior to the accident. Although she stated that she was wide awake before the accident, her intermittent sleep pattern and the length of time without food may have degraded her physical stamina.

The Caroline busdriver indicated that he had slept for about 3 1/2 hours (9 p.m. to 12:30 a.m.) before the trip. Also, he had been driving for about 5 1/2 hours when the accident occurred. Although he also stated that he was wide awake while he was driving, the small amount of rest he received prior to the trip, in combination with night driving, may have affected his ability to operate the bus.

The Safety Board concluded in its investigation that the limited rest both busdrivers received prior to the accident trips was one of several physiological factors that may have caused these busdrivers to be inattentive to their driving tasks.

Therefore, the National Transportation Safety Board recommends that Greyhound Lines, Inc.:

> Implement a new driver certification program designed to identify those drivers experiencing driving-skill-related difficulties as they progress through the training, licensing, and cubbing processes. The program should include a provision for remedial training and supervised behind-the-wheel driving experience. (Class II, Priority Action) (H-92-13)
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> Review the "cubbing" program as currently defined to ensure that it is being consistently adhered to throughout the company. (Class II, Priority Action) (H-92-14)
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> Standardize the process for developing and presenting route directions provided to drivers and ensure that the directions are correct and easy to comprehend. (Class II, Priority Action) (H-92-15)
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> During cubbing, provide new busdrivers with behind-the-wheel training that will prepare them to drive during conditions frequently encountered in their operating regions, such as mountainous terrain, inclement weather, or excessive traffic congestion. (Class II, Priority Action) (H-92-16)
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> Develop effective policies that allow employees to turn down driving assignments and report off duty when they are impaired by lack of sleep or are otherwise unfit for duty. (Class II, Priority Action) (H-92-17)

Also as a result of its investigation, the Safety Board issued Safety Recommendation H-92-18 to the U.S. Department of Labor.

COUGHLIN, Acting Chairman, and LAUBER, HART, HAMMERSCHMIDT, and KOLSTAD, Members, concurred in these recommendations.

By: Susan M. Coughlin
Acting Chairman