



## National Transportation Safety Board

Washington, D. C. 20594

Safety Recommendation

Date: December 21, 1990 In reply refer to: H-90-98

Mr. Donald C. Schramm Hamilton County Engineer 700 County Administration Building 138 East Court Street Cincinnati, Ohio 45202

On May 26, 1989, about 5:25 p.m. eastern daylight time, a 140-foot section of the 556-foot Harrison Road temporary bridge over the Great Miami River fell about 40 feet into the rain-swollen river after a pile bent collapsed. Seven witnesses reported that a passenger car and a pickup truck fell into the river. However, only a passenger car and the bodies of the car's two occupants have been recovered from the river. No other vehicles were found in the river nor are any persons reported missing in the Miamitown area. Witnesses reported an unusual amount of debris floating down the river and striking the pile bents of the bridge prior to the collapse. Although the weather was clear and dry, flooding conditions existed at the time of the collapse and the river had overflowed its banks onto the flood plain.<sup>1</sup>

In May 1990, the Safety Board contracted with the University of Maryland (UMD) to conduct structural calculations to determine the lateral load capacity of the collapsed structure and the ability of the bridge to meet American Association of State Highway and Transportation Officials (AASHTO) lateral load specifications. Two types of computer analysis were carried out to determine the lateral load capacity and the sequence of failure from both elastic buckling<sup>2</sup> and an elasto-plastic<sup>3</sup> type failure.

<sup>&</sup>lt;sup>1</sup>For more detailed information, read Highway Accident Report--"Collapse of Harrison Road Bridge Spans in Miamitown, Ohio, May 26, 1989" (NTSB/HAR-90/03).

<sup>&</sup>lt;sup>2</sup>Elastic buckling analysis is a method used to determine the upper bound of the load-carrying capacity of a structure before buckling occurs.

<sup>&</sup>lt;sup>3</sup>Elasto-plastic analysis is a method used to determine the upper bound of the load-carrying capacity of a structure before plastic deformation occurs.

In performing its analysis, the UMD assumed that the pile bent failure resulted from some type of elasto-plastic yielding that led to the formation of plastic hinges. The UMD analysis indicated that at a combined impact and accumulated debris load of 7.5 tons, plastic hinges would begin to form. The UMD also concluded that collapse would occur when a critical number of plastic hinges<sup>4</sup> had developed throughout the substructure, at a combined impact and accumulated debris loading between 11 and 12.5 tons. Based on UMD's engineering analysis and the physical evidence, the Safety Board concludes that the collapse of pile bent 2 resulted from the formation of plastic hinges due to a combination of impact and accumulated debris loading on the upstream side of the pile bent.

The Safety Board's review of the National Engineering and Contracting Company (NECC) temporary bridge design indicates that the bridge was designed in accordance with AASHTO (HS20-44) vertical loading and with the Ohio Department of Transportation (ODOT) waterway opening specifications for temporary structures. At the Safety Board's request, the UMD reviewed the NECC temporary bridge to determine whether it would have met AASHTO specifications for group loading combinations and found that it did not. According to the UMD report, if the NECC temporary bridge had been designed to conform with AASHTO lateral load specifications, pile bent 2 would have had a safe load capacity of about 23 tons instead of its actual safe load capacity of about 3.5 tons. The designer of the NECC temporary bridge believed that the bridge's substantial vertical load design factor of safety (3.5 to 1) would also accommodate any lateral loads that the bridge would experience. As illustrated by this collapse, an increase in the vertical load capacity of a bridge may not result in a similar increase in its lateral load capacity. Therefore, the Safety Board concludes that it was inappropriate for NECC to assume lateral load capacity for the temporary bridge simply by providing a substantial vertical load factor of safety in its design calculations. Furthermore, the Safety Board concludes that had the NECC temporary bridge been designed for lateral loads such as those specified by AASHTO, the bridge would have withstood the combined debris loads that caused the collapse.

The Hamilton County Engineer's (HCE's) office uses consultants in the design, construction, and review of county projects because it does not have a sufficient engineering staff for these functions. Although the HCE reviewed NECC's temporary bridge design plans for construction purposes, Graham, Obermeyer & Partners, Ltd. (GOP) was retained to perform a design review of the proposed alternate bridge plans. During the review, GOP raised questions about NECC's design, noting that it included no calculations for lateral loading. The HCE did not require NECC to make lateral load calculations or design modifications to address GOP's concerns. As a result, the NECC temporary bridge was constructed with little consideration for lateral loads. Had the HCE's office required NECC to perform lateral load calculations, the office would have discovered that the NECC temporary bridge design had a low lateral load capacity. The Safety Board concludes that HCE's approval of the NECC design without requiring design calculations for lateral loads

<sup>&</sup>lt;sup>4</sup>When the number of plastic hinges formed exceeds those required for elastic stability, the overall collapse of the pile bent occurs.

resulted in the construction of a bridge that was inadequate for the lateral loading conditions imposed on it.

Although the construction crew was not at the site on the day of the accident, the Hamilton County assistant bridge engineer stopped by to check the work status. While he was at the site, the water level increased from 13 feet to 18 feet on the gauge. He stated that he was not alarmed by this because earlier in the week (3 days before the collapse) the river gauge had read 21 feet. He testified at the Safety Board's public hearing that there were no written procedures or policies for closing bridges.

An NECC superintendent stopped by to check the construction site about 4:20 p.m. He did not notice anything unusual about the bridge but was alarmed by a telephone pole leaning precariously toward it. According to testimony at the Safety Board's public hearing, the superintendent apparently believed that he needed to get permission from the HCE's office before taking action to close the bridge. In addition, HCE employees testified that they expected to be contacted regarding a decision to close the bridge. Even though the superintendent's actions were not in response to a potential collapse of the bridge, had a procedure been in place that provided the superintendent with the authority to close the bridge, he could have closed it before the collapse.

At the time of the collapse, the HCE knew that lateral loads had not been calculated in the design of the temporary bridge and was aware of the flood conditions during the week preceding the collapse. Because the lateral design capacity of the bridge was not known, the HCE should have initiated procedures for monitoring the bridge during the flood conditions. During the initial contractual arrangements, the HCE's office and NECC should have agreed on procedures for monitoring and closing the temporary bridge structure. The Safety Board concludes that the HCE's failure to establish a policy and to develop procedures for monitoring and closing the temporary bridge during flooding conditions contributed to the severity of this accident. The Safety Board believes that the HCE should establish policies and develop procedures for bridge closure. Furthermore, the Safety Board believes that all States should require that any bridges susceptible to hydraulic and debris loading be monitored during flood events to ensure that they are closed when lateral loads exceed the design loads.

Therefore, the National Transportation Safety Board recommends that the Hamilton County Engineer's Office:

Require that bridge design capacities be determined and establish policies and procedures for monitoring and closing public highway bridges when conditions exceed the design capacity of the structure. (Class II, Priority Action) (H-90-98)

Also, as a result of its investigation, the Safety Board issued Safety Recommendations H-90-99 through -102 to the Ohio Department of Transportation; H-90-103 through -106 to the Federal Highway Administration; H-90-107 through -109 to the American Association of State Highway and Transportation Officials; and H-90-110 to the U.S. Geological Survey. The National Transportation Safety Board is an independent Federal agency with the statutory responsibility "to promote transportation safety by conducting independent accident investigations and by formulating safety improvement recommendations" (Public Law 93-633). The Safety Board is vitally interested in any action taken as a result of its safety recommendations. Therefore, it would appreciate a response from you regarding action taken or contemplated with respect to the recommendation in this letter. Please refer to Safety Recommendation H-90-98 in your reply

KOLSTAD, Chairman, COUGHLIN, Vice Chairman, and LAUBER, BURNETT, and HART, Members, concurred in this recommendation.

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y: James L. Kolstad Chairman