National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: December 20, 2001

In reply refer to: H-01-36

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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 organization 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 appropriateness of the actions of the truckdriver, pilot car drivers, and police escorts and the weaknesses in the planning, coordination, and execution of this oversize/overweight movement. The recommendation is derived from the Safety Board's investigation of the January 28, 2000, tractor-combination vehicle and train collision in Glendale, California,[1] and is consistent with the evidence we found and the analysis we performed. As a result of this investigation, the Safety Board has issued eight safety recommendations, one of which is addressed to the International Association of Chiefs of Police and the National Sheriff's Association. 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.

On January 28, 2000, about 5:56 a.m. in Glendale, California, a tractor-combination vehicle, operated by Mercury Transportation, Inc., was transporting an oil refinery condenser

[1] For additional information, read National Transportation Safety Board, *Collision Between Metrolink Train 901 and Mercury Transportation, Inc., Tractor-Combination Vehicle at Highway-Railroad Grade Crossing in Glendale, California, on January 28, 2000*, Highway Accident Report NTSB/HAR-01/02 (Washington, DC:NTSB, 2001).

unit. The vehicle missed a turn in its planned route, traversed a highway-railroad grade crossing, turned around, and was attempting to retraverse the crossing when it became lodged on the railroad tracks. About 90 seconds later, northbound Metrolink commuter train 901, operated by the Southern California Regional Rail Authority, collided with the semitrailer. The engineer, conductor, and four passengers received minor injuries. Total damages were estimated to be over $2 million.

The National Transportation Safety Board determined that the probable cause of the collision of the Metrolink passenger train with the tractor-combination vehicle was (1) inadequate preparation and route planning for the movement, (2) poor coordination of the movement among the truckdriver, pilot car drivers, police escort, and permitting authorities; and (3) a lack of recognition of the potential hazard caused by the accident vehicle at the grade crossing. Contributing to the accident was the fatigue of the pilot car drivers and the truckdriver.

The transportation of this oversize/overweight load covered over 2,100 miles through 4 States; involved 5 pilot car companies, 2 permit companies, the permit issuing offices of 4 States, and in California, 12 local jurisdictions; and had been under way for 22 days when the accident occurred.

At the time of the accident, the California Highway Patrol (CHP) had policies in place governing the movement of oversize/overweight vehicles but did not provide specific training for officers escorting these vehicles. The policies addressed topics such as the condition of the oversize/overweight vehicle, the truckdriver's duty status, placement of pilot cars, and permit documentation. Although the CHP policy was to do so, neither of the CHP teams involved in this accident examined the truckdriver's logbooks. The first team said they assumed the truckdriver had gotten enough rest during the previous night near the Arizona border before the California segment of the convoy movement began. Although the truckdriver said that he told the second CHP team in Adelanto, California, "he was near the end of his available hours of service," they deny that hours of service were discussed. If the second CHP team had examined the truckdriver's logbooks, they could have known his duty status and could have stopped the move at a safe place before the truckdriver was out of available hours and fatigued due to lack of sleep.

In addition, at the beginning of both segments of the move in California, the CHP officers performed a cursory examination of the permits to check the routes. However, the CHP officers did not examine all permits, including the local permits, to determine their validity, the special conditions including the department of public works escorts and local curfews, and the routes. Had they examined the local permits, they would have realized that the truck should not have entered the city of Los Angeles without the department of public works escort and that the convoy only had permit applications for Glendale and Hawthorne, California. Therefore, the Safety Board concludes that the CHP officers missed the opportunity to identify and prevent the subsequent fatigued condition of the truckdriver and the two pilot car drivers and the opportunity to identify inconsistencies between the proposed movement and the permits.

After the accident, the CHP made changes to its policy involving the movement of oversize/overweight loads (variance or superloads). The CHP now requires its officers to: (1) compare the route survey and permitted routes, (2) hold safety briefings to discuss routing and special conditions of the permits before the move begins, and (3) park the load if it becomes off

route. The Safety Board supports these actions. Nonetheless, as in the case of the truckdriver and pilot car drivers, the Safety Board concludes that had the CHP officers received training that emphasized the hazards of railroad grade crossings for oversize/overweight vehicles, the officers may have recognized the potential hazard and notified the railroad that the accident vehicle was about to traverse the tracks.

Therefore the National Transportation Safety Board recommends that the International Association of Chiefs of Police and the National Sheriffs' Association:

> Notify your members of the circumstances of the Glendale, California, accident and encourage them to train their officers to make sure (1) that documentation regarding permits is reviewed and verified; (2) that safety briefings to discuss routings and special conditions, including the hazards associated with moving oversize/overweight vehicles over grade crossings, are conducted; (3) that provisions for handling off-route loads are in place; and (4) that necessary notification to the railroads is made before an oversize/overweight vehicle is escorted across a highway/rail grade crossing. (H-01-36)

The Safety Board also issued safety recommendations to the Federal Highway Administration; Federal Motor Carrier Safety Administration; American Association of State Highway and Transportation Officials; American Association of Motor Vehicle Administrators; Commercial Vehicle Safety Alliance; Specialized Carriers and Rigging Association; California Professional Escort Car Association; Texas Pilot Car Association; United Safety Car Association; and city of Glendale, California. In your response to the recommendation in this letter, please refer to Safety Recommendation H-01-36. If you need additional information, you may call (202) 314-6440.

Chairman BLAKEY, Vice Chairman CARMODY, and Members HAMMERSCHMIDT, GOGLIA, and BLACK concurred in this recommendation.

Original Signed

By: Marion C. Blakey
Chairman