

**Testimony of
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National Transportation Safety Board
before the
Committee on Transportation and Infrastructure
Subcommittee on Highways and Transit
U.S. House of Representatives
“Motor Carrier Safety: The Federal Motor Carrier Safety
Administration’s Oversight of High Risk Carriers”
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Good afternoon Chairman DeFazio, Ranking Member Duncan, and Members of the Subcommittee. Thank you for allowing me the opportunity to present testimony on behalf of the National Transportation Safety Board regarding the Federal Motor Carrier Safety Administration’s (FMCSA) Oversight of High Risk Carriers. I am privileged to represent an agency that is dedicated to the safety of the traveling public.

Overview

As you know, the Safety Board is charged with investigating major transportation accidents, including highway accidents, determining their probable cause, and making recommendations to prevent similar accidents from happening again. Changes in highway or vehicle design, driver training, occupant protection, and regulatory oversight are frequently recommended.

Environment

Every day there are approximately 19,000 accidents on our nations highways causing over 43,000 fatalities and 3 million injuries each year. The economic cost of these accidents is estimated to be about \$231 billion a year, or over \$800 for every person living in the United States. Without even attempting to calculate the emotional losses to the families of these victims, just the economic cost is a tremendous burden on our society. Accidents involving large trucks comprise approximately 10% of the fatalities on our highways.

Highway accident investigations present their own set of unique circumstances for the Board. As you know, the regulation and oversight of the aviation industry is solely a Federal function and receives oversight solely from the Federal Government through the Federal Aviation Administration and accident investigation by the NTSB.

In contrast, highway accident investigation and regulation is very decentralized. Virtually all of the 7 million highway accidents are investigated at the state and local level by over 18,000 police departments who employ some 800,000 staff. They

investigate the majority of these accidents and provide an invaluable service to the safety community by documenting the circumstances of these accidents. Their hard, dedicated work greatly assists the Board in our investigations and the data they gather feeds into national databases that assists in the decision making of federal regulator agencies such as the National Highway Traffic Safety Administration (NHTSA), the FMCSA, the Federal Highway Administration (FHWA) and others.

However, in this highly decentralized environment, the Safety Board provides a unique service. The Board is virtually the only organization that conducts comprehensive, thorough highway accident investigations that drill down into the root cause of accidents. These investigations are conducted in the same objective, comprehensive, and independent manner as the NTSB's aviation investigations and we usually find root causes that are not readily apparent from more cursory investigations conducted by state and local governments. Our investigations afford us the opportunity to make safety recommendations on highway safety issues that other organizations may be unaware of or may have overlooked.

Accident Selection Criteria

Because of the Board's small size our effectiveness depends on our ability to select the most appropriate accidents and safety issues to investigate each year; issues and accidents that will lead to recommendations that will make a substantial contribution to the safety of the nation's highway system. Given the volume of highway accidents, this is not an easy task, and precludes any rote formula for selecting accidents.

Recognizing this, the Board's mandate in Chapter 11 of *United States Code* 49 is very broad. It charges the NTSB with investigating "highway accidents, including railroad grade crossing accidents, the Board selects in cooperation with a State." With 7 million accidents per year (19,000 per day), the Board must be highly selective in choosing accidents that will identify nation-wide highway safety issues. Therefore, before we launch on an accident, we ask four basic questions:

- Is there high public interest?
- Are there potentially new issues, which we or others have not addressed?
- Can we make a difference?
- Do we have the resources?

Recent Safety Issues Uncovered

The Board's small highway staff delivers considerable value for the citizens of the United States by thoroughly investigating selective accidents and identifying new safety issues. Just in the past year the Safety Board has addressed a number of important highway safety issues including highway median barriers, toll plaza designs, collision warning systems, heavy vehicle and passenger vehicle incompatibility highway construction oversight, cell phone use by bus drivers, motorcoach occupant protection,

inconsistencies in Federal accident databases, emergency egress from motorcoaches, fire resistance of motorcoach materials and designs, motorcoach wheel bearing maintenance, transportation of aluminum cylinders, emergency transportation of persons with special needs, and motorcycle safety.

Today I would like to focus on the following issues involving truck and motorcoach safety:

- FMCSA Oversight
- FMCSA's Compliance Review Process
- Motorcoach Maintenance and Oversight by FMCSA
- Medically Unqualified Drivers
- EOBRs for HOS

One of the reasons I am particularly proud to work for the Safety Board is that when tragedies do occur, the Safety Board restores the public's confidence in our transportation systems by conducting thorough, objective and transparent investigations. Ultimately the Safety Board issues recommendations to fix the system so similar tragedies can be prevented in the future.

Boston "Big Dig" Tunnel Accident

For example, when the ceiling panels collapsed in one of the Big Dig tunnels in Boston last year, the Congress immediately turned to the Safety Board to investigate this tragedy because of our reputation for thorough, independent accident investigations; and our independence is the key. Any number of other organizations could have conducted an investigation, and many still are, but for such a high-profile, high-cost, high-visibility project as the Big Dig, with all the problems that it has had, the Congress recognized that the public needed an independent body to lead this investigation.

Just yesterday the Board met to discuss the final report for this complex investigation. The Board had excellent cooperation and invaluable assistance from the U.S. Department of Justice – U.S. Attorney's Office for Massachusetts, the Department of Transportation, Office of the Inspector General, the FHWA, the Office of the Massachusetts Attorney General, and the Massachusetts State Police.

As you may recall, the accident occurred on July 10, 2006 when a section of the ceiling panels of the D Street portal of the I-90 connector tunnel became detached from the tunnel and fell onto the roof of a sedan, killing one of the two occupants. A total of about 26 tons of concrete and suspension hardware fell onto the vehicle.

This investigation presented its own unique set of issues, including:

- Understanding the basic structural properties of epoxy that was used to suspend the concrete panels;

- Understanding the differences between different types of epoxy and how they perform over time;
- Tunnel inspection requirements;
- Tunnel ceiling designs and construction; and
- The decision process in determining the design, materials, and construction of the tunnel ceiling.

The 30 NTSB staff that worked on this investigation (almost 10 percent of the agency) examined the role of 24 organizations (15 of which were potentially associated with the cause), sifted through 400,000 documents, and completed the investigation and report in one year (roughly half the time of an average investigation).

FMCSA Compliance Review Process

In 2000, the Board added the issue area of commercial truck and bus safety to our “Most Wanted List of Transportation Safety Improvements”. Since that time, the issues within this broad category have changed somewhat, however, the Board continues to address a number of critical issues regarding trucks, buses, and the safety of our nations highways.

One issue in this area is motor carrier safety fitness ratings. The recommendation on the Most Wanted List urges the FMCSA to:

“Change the way safety fitness ratings are determined so adverse vehicle and driver performance alone are sufficient to result in an overall unsatisfactory rating for the carrier.”

The Board originally issued this recommendation in 1999 in a Special Study on Selective Motorcoach Issues. We reiterated the recommendation in 2002 in our Mountainburg, Arkansas truck/school bus accident report and again in our 2007 report on the motorcoach fire that occurred near Dallas, Texas killing 23 passengers. Our goal is to prevent motor carriers from putting vehicles with mechanical problems on the road and unqualified drivers behind the wheel.

Currently, motor carriers are given safety ratings based on compliance reviews conducted by the FMCSA. Carriers are rated on six safety fitness factors:

- General – including financial responsibility, insurance coverage, drug and alcohol programs
- Driver – including qualifications and training
- Operations – including management controls, scheduling practices, allowing violations of rules, false reports, failing to maintain records
- Vehicle – including maintenance
- Hazardous materials – including failure to follow regulations, and
- Accident rate

A motor carrier can receive an unsatisfactory overall rating if two elements are rated unsatisfactory. An overall unsatisfactory rating can lead to a carrier being ordered to cease operations.

However, the Safety Board's investigations have demonstrated that the two most important factors in safe motor carrier operations are the operational condition of the vehicles, and the performance of the drivers who drive them.

Since this recommendation was originally issued and later reiterated in two accident reports, the FMCSA has planned or carried out a variety of efforts to address our concerns. For example, there was a proposed NPRM in 2003, and a review of the SafeStat system in 2004 (SafeStat is the system that helps determine which companies should be subject to compliance reviews). However, the same system is still in place and the recommendation has not yet been satisfied.

For the safety of all highway users, the Board continues to believe that a motor carrier that does not ensure either the safe operation of its vehicles or drivers should receive an overall unsatisfactory safety rating.

In June of last year, the FMCSA briefed the Safety Board on their "Comprehensive Safety Analysis (CSA) 2010 Initiative" which they indicated would include a complete evaluation of the compliance review process leading to the development of a new performance based operational model for determining motor carrier safety, emphasizing preventative measures and early detection for unsafe driver and carrier conditions. Under CSA 2010, the FMCSA plans to decouple the safety fitness rating from the compliance review. They have started the process of developing a new safety fitness rating methodology that would be based on an objective measure of a driver or carrier's safety performance data. These safety ratings would be issued to all drivers and carriers. FMCSA expects to begin pilot testing the new rating system in fiscal year 2008.

Although late in coming, the Board believes FMCSA's current efforts represent a comprehensive review of the process of determining the safety of commercial motor carriers and the development of new system to accomplish that. Still, the Board continues to monitor FMCSA's actions and is concerned that accidents continue to occur involving motor carriers with poor oversight of their drivers and vehicles.

Oversight of Motorcoach Maintenance and Operations

As an illustration of the potential consequences of poor oversight of motorcoach operations, especially concerning the vehicle, the Board recently completed an investigation into a motorcoach fire near Dallas, Texas.

On September 23, 2005, a fire engulfed a motorcoach carrying elderly evacuees away from the predicted path of Hurricane Rita near Dallas, Texas. The 44 passengers

were from an assisted-living facility in Bellaire, Texas, and many needed to be carried or assisted onto the motorcoach by firefighters or nursing staff. Boarding took almost 2 hours. Twenty-three elderly passengers were unable to escape the blaze and died.

The following safety issues, related to the fire, were identified in this investigation and the Board made recommendations in each of these areas:

- Emergency egress from motorcoaches;
- Fire resistance of motorcoach materials and designs;
- Transportation of partially pressurized aluminum cylinders; and
- Vehicle fire reporting and inadequate and inconsistent data within Federal accident databases.

However, the fire in this accident would not have occurred had the motorcoach been properly maintained. The Safety Board determined that the cause of the fire was insufficient lubrication in the right-side tag axle wheel bearing assembly of the motorcoach, which resulted in increased temperatures and subsequent failed wheel bearings. The high temperatures resulting from the friction led to the ignition of the tire and a catastrophic fire. This occurred because the motorcoach operator, Global Limo, Inc., failed to detect this lack of lubrication and FMCSA failed to provide proper oversight of the motor carrier through its compliance review process.

Here is what the Board found:

- The accident motorcoach was mechanically unsafe because the right-side tag axle wheel bearing assembly lacked sufficient lubrication, which resulted in high frictional forces and high temperatures, causing the wheel bearings to fail, overheat and ignite the tire.
- Because neither Global nor its employees routinely inspected the hub oil level or undercarriage of the wheel well, they did not discover the lack of lubrication of the tag axle wheel bearings. This disregard for vehicle maintenance, pre-trip inspections, and post-trip driver vehicle inspection reports led to a wheel bearing failure that resulted in a catastrophic fire and loss of life.
- Global Limo Inc. violated several Federal safety regulations pertaining to its drivers and vehicles, thereby exhibiting a lack of concern for safety management controls. For example, with reference to driver violations, they did not ensure that their drivers were properly licensed to drive a motorcoach in the United States, and failed to conduct the required post-accident alcohol and illicit drug testing. With reference to vehicle violations, they operated a passenger-carrying commercial vehicle, which had an expired temporary trip tag, was not registered in the United States, displayed the license plate from another vehicle, and had not been systematically or adequately maintained. These violations especially concern the Safety Board because we have repeatedly made recommendations

to FMCSA to place greater emphasis on driver and vehicle violations in its compliance review process.

- Federal regulations and inspection criteria do not require inspection of wheel bearings to ensure adequate lubrication and thereby prevent wheel bearing failure and resulting wheel well fires.
- Most motorcoach maintenance manuals do not provide a specific warning of the danger of inadequate wheel bearing lubrication and the potentially serious consequences of wheel bearing failures.
- Although FMCSA collects data on numerous safety violations when it conducts compliance reviews of motor carriers, ironically, approximately 85% of those violations are not included in the calculations of the motor carriers' rating. By not recognizing these violations in its calculations, FMCSA is allowing potentially unsafe carriers to continue to operate without consequence.
- Finally, as we have done in several accident investigations over the past 8 years, the Safety Board again concluded that the current FMCSA compliance review process does not effectively identify unsafe motor carriers and prevent them from operating, especially when violations are found in the areas of driver and vehicle safety.

Unfortunately, FMCSA is only able to conduct compliance reviews for a small fraction of the almost 911,000 motor carriers in this country. However, in this particular accident, numerous driver and vehicle safety violations were uncovered in a review performed by the Texas Department of Public Safety (DPS) in April 2002. At the time, the Texas DPS had no authority to force Global to cease operations. In February 2004, FMCSA conducted a compliance review of Global in which it found similar violations pertaining to drivers and vehicles. However, FMCSA rated Global as "satisfactory." Finally, 19 months later, after the bus fire near Dallas, FMCSA went back to Global and conducted another compliance review in September 2005. In this review, FMCSA found many of the same violations as in its previous compliance review; however, this time FMCSA gave Global a safety rating of "unsatisfactory" and declared that Global's operations created an "imminent hazard" to public safety. FMCSA issued an order for Global to cease operations.

Concerned that motor carriers with significant regulatory violations for drivers and vehicles are still receiving satisfactory ratings, the Safety Board once more focused on Federal standards for determining the safety fitness of carriers. As a result, the Board made the following recommendations:

- The Safety Board asked FMCSA to revise the Federal Motor Carrier Safety Regulations to prohibit a commercial vehicle from operating with wheel seal or other hub lubrication leaks.

- To protect the traveling public until FMCSA completes and implements its Comprehensive Safety Analysis 2010 Initiative, the Board asked FMCSA to issue an Interim Rule to include all Federal Motor Carrier Safety Regulations in the current compliance review process so that all violations of regulations are reflected in the calculation of a carrier's final rating.
- The Board asked that motorcoach maintenance manuals be revised to emphasize the importance of wheel bearing lubrication. These manuals need specific warnings that daily inspection of hub oil levels and wheel seals is vital to preventing wheel bearing failure and that bypassing this requirement is a dangerous practice that can lead to a wheel fire or other serious consequences.
- Finally, the Board reiterated its long-standing recommendation to FMCSA to change the safety fitness rating methodology so that adverse vehicle or driver performance-based data alone are sufficient to result in an overall unsatisfactory rating for a carrier.

Medically Unqualified Drivers

Another major oversight issue for the Board concerns medically unqualified drivers.

The Safety Board has long had an interest in the link between commercial driver fitness and transportation safety. Following its investigation of a Mothers Day, 1999 motorcoach accident in New Orleans involving a medically unfit driver that resulted in 22 fatalities, the Safety Board issued 8 recommendations to the FMCSA outlining a comprehensive medical oversight program for interstate commercial drivers. These recommendations have been on the Board's Most Wanted List for several years. They include:

Develop a comprehensive medical oversight program for interstate commercial drivers that contains the following program elements:

- Medical certification regulations are updated periodically to permit trained examiners to clearly determine whether drivers with common medical conditions should be issued a medical certificate. (H-01-19)
- Individuals performing medical examinations for drivers are qualified to do so and are educated about occupational issues for drivers. (H-01-17)
- A tracking mechanism is established that ensures that every prior application by an individual for medical certification is recorded and reviewed. (H-01-18)
- Individuals performing examinations have specific guidance and a readily identifiable source of information for questions on such examinations. (H-01-20)

- The review process prevents, or identifies and corrects, the inappropriate issuance of medical certification. (H-01-21)
- Mechanisms for reporting medical conditions to the medical certification and reviewing authority and for evaluating these conditions between medical certification exams are in place; individuals, health care providers, and employers are aware of these mechanisms. (H-01-22)
- Enforcement authorities can identify invalid medical certification during safety inspections and routine stops. (H-01-23)
- Enforcement authorities can prevent an uncertified driver from driving until an appropriate medical examination takes place. (H-01-24)

As you know, the Safety Board tracks and classifies the recipient's responsiveness to our recommendations. In the case of the above recommendations to the FMCSA, only the first recommendation (H-01-19) is classified as an "Acceptable Response". The others are all currently classified as "Unacceptable Response".

The FMCSA issued a Notice of Proposed Rulemaking (NPRM) in November of 2006 on, *Medical Certification Requirements as Part of the Commercial Driver's License (CDL)*. This NPRM proposes to amend the Federal Motor Carrier Safety Regulations to merge information from the medical certificate into the CDL process – a concept the Board has long advocated.

FMCSA's NPRM, to a certain extent, addresses two of the recommendations noted above: Safety Recommendations H-01-23 and -24. The NPRM proposes allowing enforcement authorities to identify, during safety inspections and routine stops, those drivers who fail to submit either an original or a copy of their latest medical certificate to the State Driver Licensing Agency (SDLA). As currently written, it would permit authorities to place out of service such drivers and those for whom 60 days had elapsed from the expiration date of their latest submitted certificate. However, the NPRM does not establish a comprehensive medical oversight program as recommended by the Safety Board.

The Board made the following observations in reviewing the NPRM:

Track Medical Certification Examinations

In general, neither the NPRM, nor any other publicly announced FMCSA initiatives, create a process to review or track medical certification examinations or decisions, as recommended in H-01-18 and -21 or to create a mechanism for reporting medical conditions identified between examinations, as recommended in H-01-22. The Safety Board is convinced that for any commercial driver medical oversight program to be effective, a systematic approach is necessary that addresses all of the issues in the

eight recommendations. Accordingly, these deficiencies in the NPRM may limit its effectiveness.

No Mechanism to Ensure Medical Certificate Validity

The Safety Board is concerned that, because the certificate form is not a controlled document, has no standard appearance, and may be freely reproduced; a means is needed for the SDLA to verify that forms submitted by drivers are issued in accordance with existing regulations. In at least one instance, an insulin-dependent bus driver who was involved in a single-vehicle, run-off-the-road accident possessed an expired medical certificate that had been altered to indicate that it was current (Bay St. Louis, Mississippi accident, May 2001, Safety Board accident number HWY01IH024).

Additionally, because drivers are not prevented from visiting multiple examiners (“doctor shopping”) in their attempts to obtain medical certificates, the Safety Board believes that a means is necessary for the SDLA to establish that a driver has not previously been denied a medical certificate.

The Safety Board also noted in its comments on the NPRM that the proposed rule does not include the commercial driver medical examiner’s phone number, currently included on the medical certificate, as one of the required CDLIS (Commercial Driver's License Information System) data fields, which may hinder authorities from calling medical examiners to confirm that they have actually issued medical certificates.

Sixty-Day Period to Downgrade the CDL

The Safety Board is also concerned about the proposed 60-day window during which the CDL may not be downgraded for drivers who have received a medical certification status of “not-qualified.” The Board is aware that examiners may time-limit certificates to periods considerably shorter than 2 years, particularly when they find medical conditions that may change over a relatively short time, or when they are awaiting additional medical information from the driver. However, the proposed 60-day window would increase such a limitation by as much as 2 months, potentially thwarting the examiner’s intent to limit the certificate of a driver with a worrisome medical condition. Although the Safety Board supports the addition of driving while in a “not qualified” status during the 60-day window as a disqualifying offense (that is, by adding it to table 2 of §383.51(c)), the Board is concerned that such an addition would not automatically permit the authorities to take an unqualified driver out of service, which could allow an identified potential safety risk to persist for as long as 60 days.

Unclear Employer Responsibilities

The Safety Board is concerned that the proposed rule contains no requirement for the SDLA to notify the employer if a driver’s CDL is downgraded due to an outdated medical certificate. Therefore, motor carriers may not know if a particular driver’s certificate has expired. As a result, this rule, as proposed, could hinder the FMCSA

from holding carriers responsible for ensuring that all their drivers are qualified beyond the time of initial hire. This creates a situation where the majority of a carrier's employees could have outdated or invalid medical certificates, and the carrier would not be required to have timely knowledge of that situation.

No Provision for State Revocation of CDL

The Safety Board is aware that several states have procedures for reporting and subsequently investigating CDL holders with medical conditions that would potentially prevent them from operating commercial motor vehicles safely, and if necessary, revoking their CDLs. However, the proposed rule does not provide for states to change the medical certification to "not qualified" when they learn that CDL holders have medical conditions incompatible with safe commercial vehicle operation.

No Provision for States or Employers to Retain Long Form

The Safety Board is concerned that the proposed rulemaking does not specifically permit states and/or employers to require copies of the medical certificate or examination form (that is, the long form) to be provided and retained for review. The Safety Board therefore suggests that the rule require (as several states already do) that the entire long form (and not just the certificate) be submitted to and retained by the SDLA for review as necessary. At an absolute minimum, the rule should clarify that states and employers be expressly *permitted* to require submission of the long form and to retain the information indefinitely.

No Provision for Medical Examiners to Retain Long Form

The Safety Board is concerned that the proposed rulemaking does not clarify that medical examiners are still required to retain the long form. This requirement currently exists only in the "Instructions for Performing and Recording Physical Examinations," which follows 49 *Code of Federal Regulations* 391.43, and there are no other requirements for this form to be retained. If the long form is not retained, medical examiners, SDLAs, and accident investigation authorities are among those who would not be able to obtain the records necessary to document drivers' known medical conditions, should the need arise.

It is also unclear why the proposed rule allows examiners to routinely eliminate medical certificates from their records once they expire, making subsequent verification difficult or impossible. As in the example above from the Bay St. Louis, Mississippi accident, a simple forged date might not be traceable because the original expired certificate would not be on file.

No Requirement for Indefinite Retention of Certificate

Finally, although the NPRM has specified a 6-month period for retaining a copy or image of the medical examiners' certificate, it is unclear to the Safety Board why the

SDLA would not be required to maintain a copy of each submitted medical certificate indefinitely. Under current regulations, this might be the only historical record of these certificates.

In general the Safety Board is disappointed at the length of time taken by the FMCSA to generate this NPRM. However, if modified to address the concerns noted above, the proposed rule may make some nominal steps towards improving safety. Unfortunately, it does not represent considerable progress toward the goal of a comprehensive medical oversight program for interstate commercial drivers that was envisioned in the Board's recommendations on this topic. This is why the Board classified the majority of the recommendations associated with this issue as "Unacceptable Action". Accordingly, the Board encourages the FMCSA to develop a more robust framework for such oversight.

Electronic On-Board Recorders (EOBR) for Hours of Service (HOS)

The final topic I would like to mention today is how technology can help prevent fatigue-related accidents by improving commercial driver compliance with the HOS regulations.

First, I would like to complement the FMCSA on beginning this process and framing the public debate by issuing an NPRM on EOBRs for HOS on January 18, 2007. Although rulemaking on this issue has the potential to greatly improve the compliance with hours-of-service rules, and ultimately reduce fatigue-related accidents, the Board believes that the currently proposed NPRM will not accomplish these goals in its present form.

The Board has a long history on this issue and continues to investigate accidents where fatigue and violations of the hours of service regulations are present.

For the past 30 years, the Safety Board has advocated the use of on-board data recorders to increase hours-of-service compliance of commercial drivers. As you know, commercial drivers are currently required to keep logbooks on the hours they drive. However, for many reasons these log books often do not reflect the true hours of operation. Because most drivers are paid by the mile, and motor carriers make more money the more miles that are driven by their drivers, neither party has adequate incentives for compliance with the hours-of-service rules. The current system of paper logbooks offers many opportunities to play fast and loose with these rules. Some unscrupulous drivers write down hours different from those that they actually drive, some maintain multiple logbooks, and some outright falsify the information. In addition, some motor carriers do not closely monitor their drivers' compliance with the rules and some may actually coach their drivers on how to fudge their logbook. It is not comical, but many in the truck and bus industry call these logbooks "comic books".

Let me summarize some of the key events that have led to the Board's position on HOS compliance.

In 1977, the Safety Board issued its first recommendation on the use of on-board recording devices for commercial vehicle hours-of-service compliance. It was in response to the FHWA's withdrawal of an Advance Notice of Proposed Rulemaking concerning the installation of tachographs in interstate buses. That recommendation proposed that the FHWA:

Conduct scientifically controlled studies to determine the effects and merits of the use of tachographs on commercial vehicles in reducing accidents. (H-77-32)

Although FHWA studied the issue, they did not make any changes.

During the 1980's, the technology for onboard recorders for hours-of-service improved dramatically. In 1990, the Safety Board first urged the FHWA to mandate the use of on-board recorders. The Board made this recommendation in its 1990 safety study on Fatigue, Alcohol, Drugs, and Medical Factors in Fatal-to-the-Driver Heavy Truck Crashes. This study concluded that on-board recording devices could provide a tamper-proof mechanism to enforce the hours-of-service regulations. The study also found that, of the 182 accidents investigated, the most frequently cited factor or probable cause in these accidents was fatigue, cited in 31 percent the cases. Alcohol was second at 29 percent. Therefore, the Safety Board recommended that the FHWA:

Require automated/tamper-proof on-board recording devices such as tachographs or computerized logs to identify commercial truck drivers who exceed hours-of-service regulations. (H-90-28)

An identically worded companion recommendation was made to the States, the Commonwealth of Puerto Rico, the Virgin Islands, and the Territories (H-90-48).

This recommendation was rejected by the FHWA and the states.

In 1995, the Board reiterated this safety recommendation (H-90-28) in its safety study on "Factors That Affect Fatigue in Heavy Truck Accidents" in which 107 heavy truck accidents were studied. The study also noted that the incidence of driver fatigue is underrepresented in the Fatality Analysis Reporting System (FARS) database.

Both the FHWA and the states failed to act on this recommendation.

In 1998, the Safety Board again advocated industry-wide use of on-board recording devices after investigating a multiple-vehicle accident that occurred in Slinger, Wisconsin, on February 12, 1997 in which 8 persons died. This time, the Board tried a different approach and made recommendations directly to industry by way of the American Trucking Associations, the International Brotherhood of Teamsters, the Motor Freight Carriers Association, the Independent Truckers and Drivers Association, the National Private Truck Council, and the Owner-Operator Independent Drivers Association, Inc. The recommendation was:

Advise your members to equip their commercial vehicle fleets with automated and tamper-proof on-board recording devices, such as tachographs or computerized recorders, to identify information concerning both driver and vehicle operating characteristics. (H-98-26) (H-98-23)

This recommendation was opposed by the industry.

In August 12, 2001, the Safety Board reiterated its position regarding the use of on-board recorders for hours-of-service compliance in its response to the FMCSA's NPRM on Hours-of-Service of Drivers. In our response, the Safety Board again requested that the FMCSA strongly consider mandatory use of EOBRs by all motor carriers to help improve hours-of-service compliance.

FMCSA did not incorporate this suggestion into the NPRM.

Finally, in April 18, 2007 the Board expressed its disappointment with FMCSA's NPRM entitled "Electronic On-Board Recorders for Hours-of-Service Compliance". Let me highlight some of the reasons why the Board felt the NPRM fell short of its intended target.

As you know, the NPRM focuses on three elements:

1. Performance-oriented standards for EOBR technology;
2. Mandatory use of EOBRs by motor carriers who are found to exhibit a pattern of violations of HOS regulations; and
3. Development of incentives anticipated to encourage voluntary industry-wide use of EOBRs.

With respect to the first element, the Safety Board is generally satisfied with the direction proposed by the FMCSA except in the area of crash protection. Performance standards offer flexibility in the face of rapid technological advances; thereby requiring minimal-to-no changes to pertinent regulations. The NPRM makes several proposals designed to ensure the security and validity of EOBR data, but it fails to address EOBR damage resistance and data survivability. Naturally, the survival of the data is important, not only for regulatory compliance, but also to assist accident investigators determine the influence of fatigue on the driver and the cause of the accident. Therefore, in its comments on FMCSA's NPRM, the Safety Board asked FMCSA to add performance standard factors that consider these issues.

Concerning the second element, the Safety Board believes onboard recorder technology should be applied to all carriers, subject to the hours-of-service regulations. We are disappointed that the proposed rules will only require EOBRs for carriers who are identified through the compliance review process as "pattern violators" of the hours-of-service regulations.

Identifying such carriers seems problematic. For example, for a carrier to be identified as such, the FMCSA must perform at least two compliance reviews on that carrier within a 2-year span. In 2005, the FMCSA was only able to perform a total of 8,097 compliance reviews on a population of approximately 911,000 active and registered carriers, meaning that less than 1 percent of all carriers were assessed for safety and fitness. Although the FMCSA uses a computerized rating methodology (SafeStat) to target potentially unsafe carriers for compliance reviews, flaws in the compliance review system guarantee that many unsafe carriers continue to evade even initial identification as an hours-of-service violator. The Safety Board has documented several instances in which carriers have received favorable compliance review ratings despite long and consistent histories of driver- and vehicle-related violations. For example, this was the case for the operator and vehicle involved in the recent investigation of the motorcoach fire that fatally injured 23 people near Dallas, Texas.

In light of the proven deficiencies in the FMCSA motor carrier compliance program, this program should not be the triggering mechanism to initiate a requirement for EOBRs. The Safety Board does not believe that the FMCSA has the resources or processes necessary to identify and discipline all carriers and drivers who are pattern violators of the hours-of-service regulations.

Consequently, a program to impose EOBRs on pattern violators that relies on the compliance program to identify such carriers seems unlikely to succeed. In addition, pattern violators of hours-of-service regulations are the carriers least likely to choose to install and use EOBRs voluntarily. The Safety Board is therefore convinced that the only effective way in which EOBRs can help stem hours-of-service violations, which the Board has linked to numerous fatigue-related accidents, is to mandate EOBR installation and use by all operators subject to hours-of-service regulations.

Additionally, the Safety Board is concerned that the NPRM proposes using EOBRs as a form of remediation or punishment, when the technology has significant potential for increasing the safety of all motorists. According to the NPRM, "... motor carriers that have demonstrated a history of serious noncompliance with the hours-of-service (HOS) rules would be subject to mandatory installation of EOBRs meeting the new performance standards." The Safety Board believes that encouraging motor carriers to perceive EOBRs primarily as a means of punishment would undermine the goal of achieving voluntary industry-wide acceptance. In fact, progressive motor carriers are using EOBRs as an effective tool in shipment tracking, equipment maintenance, and operator scheduling. In addition, EOBRs provide a more efficient and reliable way for enforcement agencies to monitor hours-of-service compliance. Finally, the Europeans for decades have required the use of digital tachographs for hours of service.

With respect to the NPRM's third element, the proposed rulemaking outlines several incentives that the FMCSA hopes will promote the voluntary installation and use of EOBRs. Among these incentives are new compliance review procedures and exemptions for certain supporting documentation requirements. The Safety Board is in favor of any incentive that fosters use of EOBRs without undermining safety; however,

the Board is skeptical whether the incentives currently proposed would be strong enough to override the financial motivation some carriers and drivers have for continuing to circumvent the HOS regulations and not use EOBRs.

In summary, the Safety Board is convinced that the regulations proposed in the current NPRM:

- Will not result in the timely and effective adoption of EOBR technology by all motor carriers,
- May serve to depict EOBRs as a punitive device rather than as one that promotes safety, and
- Will ultimately fail to reduce the number of carriers and drivers who exceed Federal hours-of-service limits.

Accordingly, the Safety Board urges the FMCSA to revise the NPRM to require that all motor carriers, subject to the HOS regulations, install and use EOBRs.

The trucking industry in the United States has already installed hundreds of thousands of devices capable of recording hours-of-service information. We believe it is past time to act and that the use of EOBRs should be mandatory throughout the industry, as are similar devices required in most of Europe.

Fatigue-related accidents continue to plague our nations highways and because fatigue, unlike alcohol or speeding, is extremely difficult to detect. In fact, fatigue is probably the most underreported causal factor in highway accidents. Electronic on-board recorders hold the potential to efficiently and accurately collect and verify the hours of service for all drivers. They will also establish the proper incentives and a level playing field for compliance with hours-of-service rules and will ultimately make our highways safer for all drivers.

Thank you again for the opportunity to testify before this committee. I would be delighted to respond to any questions you may have.