

REPORT OF THE INDEPENDENT REVIEW TEAM

JULY 15, 2014



BLUEPRINT FOR SAFETY LEADERSHIP: ALIGNING ENFORCEMENT AND RISK

Independent Review Team Appointed by

Secretary of Transportation Anthony R. Foxx
To Review the Federal Motor Carrier Safety Administration's
Safety Oversight of the Motor Carrier Industry

Independent Review Team Members:

William R. Voss (Chair) | Jacqueline A. Duley | Neil R. Eisner
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**INDEPENDENT REVIEW TEAM
WASHINGTON, DC**

July 15, 2014

Secretary Anthony Foxx
U.S. Department of Transportation
1200 New Jersey Avenue, SE
Washington, DC 20590

Dear Secretary Foxx:

We are pleased to transmit to you the recommendations of the Independent Review Team that addressed National Transportation Safety Board recommendations H-13-039 and H-13-040 regarding the Federal Motor Carrier Safety Administration (FMCSA). We believe that our recommendations can enhance the safety of the motor carrier system and hope that they will be useful to you and the FMCSA leadership.

We were privileged and honored to serve on the Independent Review Team. During our assignment, we met extensively with FMCSA staff and experts interested in or affected by motor carrier safety who volunteered their time and analysis to make this effort possible. We were extremely impressed with the cooperation provided by all. Please thank them on our behalf.



William R. Voss



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The responsibility for the recommendations and findings of this report rests solely with the IRT.

Executive Summary

The Secretary of Transportation asked the Independent Review Team (IRT) to provide actionable information for his response to National Transportation Safety Board (NTSB) recommendations issued after its investigation of four commercial vehicle crashes and to provide insights and perspectives on other opportunities for the Federal Motor Carrier Safety Administration (FMCSA) to improve motor carrier safety.

The IRT has been impressed with the talent and dedication of the people of FMCSA. These men and women demonstrate great energy and professionalism in the way they approach their duties. During the IRT's interview process they also displayed a genuine openness to new ideas and enthusiasm for positive change. In our opinion, they labor under an extraordinary operational workload and their willingness to seek more effective approaches, even while under such pressure, is noteworthy and commendable.

The IRT found that FMCSA's current compliance review (CR) process does not consistently generate the intended results. The current leaders of FMCSA share many of the concerns of the NTSB and other stakeholders about this process. Current operating conditions and methods appear to constrain FMCSA. This report is intended to assist USDOT and FMCSA in finding the best path forward for the organization.

FMCSA has multiple stakeholder groups interested in improving its performance. This review constitutes one of several initiatives to examine FMCSA performance, either underway or anticipated in the near future. There have been multiple audits and critical reviews made in the past, some by oversight agencies and some as a result of congressional interest.

Ironically, the cumulative effect of prior critiques has been to add substantial requirements for safety oversight ("mandatory CRs"), which has exacerbated the production pressure on front line staff, limited their discretion, and reduced their ability to focus their attention and actions on the risks that really count. They now seem so busy trying to keep up with their mandated investigation load that they have limited opportunity to align their operations with current and emerging risks.

FMCSA is in the midst of a major initiative to improve the effectiveness of the Agency's compliance and enforcement programs, and has reached a challenging juncture in the change management process. The IRT believes that the current operating dynamics within FMCSA require significant changes. Without these changes, the organization will have great difficulty enhancing its safety oversight of the motor carrier industry to the level everyone desires.

This report addresses some of these fundamental dynamics and presents a range of recommendations to support both incremental and transformative improvements. Most of the recommendations are directed toward FMCSA, though many of them will require the support or consent of industry, elected officials, and other stakeholders. FMCSA clearly needs the cooperation of all stakeholders in order to make substantial progress.

Compliance, Safety, Accountability Program: FMCSA needs to better align compliance and enforcement processes with the safety risks that cause crashes. The Compliance, Safety, Accountability (CSA) program is designed to do that, but it has been only partially implemented. Today the Agency has a safety measurement system (SMS) in place that is based on a motor carrier's on-road performance (thus focused on data regarding inspection results, traffic violations, and crashes). Once a motor carrier has been flagged for attention, field investigators follow up with CRs conducted at the motor carrier's place of business. These reviews focus on issues that can be examined at the office, such as: records, driver logs, maintenance programs, substance abuse control programs. In some instances, CRs focus on issues quite different from those that may have triggered the need for greater scrutiny. This disconnect affects FMCSA's everyday operations. The IRT recommends examining all options for expediting the safety fitness rulemaking, which is intended to complete the alignment. The IRT particularly recommends approaches that can increase the effective participation of stakeholders in helping to resolve this problem, with additional recommendations for interim policy changes while the rulemaking is in progress.

SMS Resource Prioritization: The IRT found that while FMCSA has a system for prioritizing its field resources to investigate high-risk carriers, it lacks a process to actively manage risk concentrations once identified. This shortcoming emerges as a factor in crashes, including those cited by the NTSB. This report offers short-term recommendations for dealing with established risk concentrations, as well as suggestions for how to make the prioritization system more targeted and nimble in the longer term.

SMS Data: The CSA program has ignited a debate across the industry regarding the appropriate use of safety data. It is now clear that this debate, if not refocused, could stall the adoption of safety practices the industry needs and the public expects. For that reason, the IRT offers proposals for incremental improvements to the SMS that may exploit common ground between the interests of FMCSA, the regulated industry, and other stakeholders.

CR Process: FMCSA is taking measures to improve the quality of its investigations. However, the investigations do not consistently result in cited violations that target the highest risk behaviors. The IRT suggests that the Agency establish, in its improvement measures, a clear priority of CR quality over numbers completed; develop a data-informed spectrum of CRs to replace the current constraining distinctions; and empower field level discretion in conducting those CRs, with a robust review/feedback process for consistency and quality.

Enforcement of Federal Motor Carrier Safety Regulations (FMCSR) Compliance: FMCSA has recently sought and been granted additional enforcement authority. However, the agency needs to improve its enforcement policies and procedures to take better advantage of this authority. The IRT suggests near-term enforcement policy changes that could enable the Agency to focus action more effectively in areas of highest risk. We also propose some valuable new additions to the range of enforcement and compliance tools available to the Agency.

Quality Assurance/Control: In an effort to achieve consistency across different investigators, divisions, and regions of the country, FMCSA has relied heavily on prescriptive rules and procedures. An accountability structure relying more on quality assurance and retrospective back-end controls would provide FMCSA field staff greater flexibility while increasing their ability to deliver important results tailored to local conditions. The IRT offers suggestions on how FMCSA might change its systems for holding field operations accountable.

Partnership with the States: FMCSA relies on state and local partnerships to carry out its responsibilities. Interviews with state employees surfaced some concerns about the equality of some of these relationships. It is clearly in all parties' interests that these partnerships be strong. The IRT offers one recommendation for ensuring that these relationships meet their purposes and public expectations.

Beyond Compliance: The IRT's tasking was initiated based on the NTSB's recommended examination of FMCSA's CR process, including focused reviews. However, we believe it is vitally important for FMCSA to move beyond its focus on conducting CRs and embrace a broader and more balanced portfolio of safety tools. Based on extensive interviews with Agency personnel and external stakeholders, the IRT is aware that FMCSA is moving in this direction, and the IRT offers an improved glide path to effective change management. The IRT suggests an array of alternative safety initiatives and programs that have been tried and tested in other industries. The IRT also discusses the role that voluntary safety programs might play in delivering safety enhancements that move substantially beyond those achievable through traditional compliance methods. In the motor carrier industry, where thousands of lives are lost and on average more than one hundred thousand are injured every year, the case for adopting a modern portfolio of strategies seems to us compelling.

Recommendations

2.1 CSA Program (Safety Fitness Determination (SFD) Rule)

Recommendation 2.1.1

FMCSA should start addressing the disconnect between the CSA system and the legacy Safety Fitness Procedure while the new SFD rule is still being considered.

- a. Establish metrics that compare violations being written by the investigator with the risk predicted by the SMS.
- b. Implement and measure policy adjustments, training, and procedures intended to better align investigative outcomes with on-road risks.

Recommendation 2.1.2

FMCSA should expedite the SFD rulemaking process and consider the use of consensus based, or facilitated, processes for the development of the rulemaking.

2.2 SMS Resource Prioritization for Motor Carriers

Recommendation 2.2.1

FMCSA should sharpen its priority-setting focus and improve the timeliness of investigator actions on those motor carriers representing the highest risk.

- a. Modify the selection formula and policies to limit the number of mandatory and other non-risk-based high-priority candidates.
- a. Seek or create relief from internally and externally generated mandates for CRs involving carriers of lower risk.
- b. Reprioritize reviews on motor carriers whose safety performance degrades after an investigation is assigned.

Recommendation 2.2.2

FMCSA management should act quickly to review resource allocation across Regions and Divisions to better align appropriate resources to the location of highest risk.

- a. Better balance Agency resources against the existing geographic pools of risk.
- b. Provide Division Administrators with the highest risk exposure with analytical capability, authority, and accountability to manage the pools of risk.

2.3 SMS Data**Recommendation 2.3.1**

FMCSA should expand its work with industry and stakeholders to develop SMS enhancements. These enhancements should enable FMCSA to better discern motor carrier management actions that lead to crashes and to allow more timely and appropriate investigation and enforcement actions.

Recommendation 2.3.2

FMCSA should re-assess its current SMS website.

- a. Continue to identify and implement methods for emphasizing absolute rather than relative individual motor carrier rankings so that it does not undermine industry's willingness to innovate and share best practices.
- b. Consider the role it will play in dissemination of safety information as the motor carrier industry matures.

2.4 Compliance Review (CR) Process**Recommendation 2.4.1**

FMCSA should ensure that the “quality over production” priority is clearly and consistently reinforced in its training programs and emphasized through Division Administer guidance to the investigators.

Recommendation 2.4.2

FMCSA should enhance its processes.

- a. Modify the CR “Comprehensive and Focused” distinctions in favor of a data-informed spectrum of compliance reviews.
- b. Provide Division Administrators and investigators discretion to determine the level and scope of a CR.
- c. Establish regular reviews and feedback processes to ensure consistency and quality.

2.5 Enforcement of FMCSR Compliance**Recommendation 2.5.1**

To allow more effective use of Agency resources, FMCSA should clarify or modify its guidance on when it is appropriate for investigators and enforcement attorneys to take enforcement actions.

- a. Develop guidance to clarify that Behavior Analysis Safety Improvement Categories (BASIC) data may be used to establish a basis for enforcement actions against patterns-of-behavior violations, such as frequent speeding citations across a carrier’s driver population.
- b. Examine current guidance on the required documentation in a CR, such as number of violations necessary to support an enforcement action, to determine whether the guidance can be changed to increase the focus on accident prevention without adversely affecting the likelihood of an enforcement action being sustained.

Recommendation 2.5.2

FMCSA should expand or improve its enforcement tools.

- a. Identify more effective tools for handling relatively minor violations.
- b. Ensure a common understanding Agency-wide of tools to penalize motor carriers that commit process violations such as failing to appear for scheduled investigations.
- c. Clarify or, if necessary, seek statutory modifications to address the problems created by the deadline for the opportunity to review imminent hazard out-of-service orders.

2.6 Quality Assurance/Control—Investigator Performance and Policy Effectiveness**Recommendation 2.6.1**

FMCSA should:

- a. Establish routine quality reviews of CR processes and outcomes by Division Administrators in each state such as those applied during the 2013 Quick Strike.
- b. Create a mechanism by which practices and outcomes across divisions and regions are reviewed to identify best practices, problem areas, and patterns that indicate training may be needed.

- c. Perform consistent, detailed, headquarters evaluations of enforcement effectiveness—by enforcement tool, by division, and by case/investigator; use the analysis to provide regular feedback to divisions and regions about their effectiveness and to inform Agency adjustments to policies and expectations.

2.7 Partnering with the States

Recommendation 2.7.1

FMCSA should lead a joint federal/state initiative to assess the quality and effectiveness of the partnership working level relationships, followed by developing specific measures as required to ensure the partnership working environments remain consistent with the respective senior leadership expectations.

3.0 Alternatives to a Compliance-Centric Enforcement Strategy

Recommendation 3.1

FMCSA, the motor carrier industry, and other stakeholders should develop a mechanism that allows for the cooperative development and coordinated implementation of voluntary safety programs.

Recommendation 3.2

FMCSA should work closely with the motor carrier industry and other stakeholders to develop approaches that will enable small motor carriers to effectively participate in any voluntary safety program.

1.0 Introduction

The Federal Motor Carrier Safety Administration (FMCSA) was established within the Department of Transportation (DOT) on January 1, 2000, pursuant to the Motor Carrier Safety Improvement Act of 1999 (Public Law 106-159). Prior to this legislation, motor carrier safety responsibilities were under the jurisdiction of the Federal Highway Administration. FMCSA's mission is to reduce crashes, injuries, and fatalities involving Commercial Motor Vehicle (CMV) transportation through education, innovation, regulation, enforcement, financial assistance, and partnerships. The Agency has a vision for the future that moves towards zero CMV crashes, injuries, and fatalities. FMCSA employs approximately 1,100 employees, nearly 900 of whom work in field offices (Divisions) in all 50 states, the District of Columbia, and Puerto Rico. FMCSA regulates over 8 million vehicles, and 7 million active commercial driver licensees. FMCSA also provides regulatory oversight of approximately 525,000 active interstate motor carriers¹ operating these vehicles and employing these drivers.

FMCSA maintains a strong relationship with its state and local grantees to accomplish the shared goal of reducing roadway crashes, specifically CMV crashes and their associated injuries and fatalities. While FMCSA employs approximately 1,100 people, its state and local grantees employ more than 12,000 safety professionals. State and local grantees currently conduct more than 3.4 million of the 3.5 million CMV roadside inspections; more than 34,000 of the 38,000 new entrant safety audits; and more than 6,000 of the 16,000 (CRs) conducted each year.

1.1 NTSB Issues Recommendations to Secretary of Transportation

In a letter dated November 5, 2013, to Anthony R. Foxx, Secretary of Transportation, the National Transportation Safety Board (NTSB) cited four CMV crashes that resulted in 25 deaths and 83 injuries.² Two of the crashes involved motor coaches and two involved commercial property operations. In its letter, NTSB raised concerns regarding the quality of FMCSA's compliance review processes and issued two recommendations—H-13-039 and -040.

H-13-039	Conduct an audit of the compliance review processes used by the FMCSA to determine (1) why inspectors are not identifying all violations of safety regulations by motor carriers undergoing review, and (2) why FMCSA's quality assurance efforts are not fully effective in assessing the accuracy and completeness of compliance reviews; once these determinations have been made, require FMCSA to revise its processes to correct these deficiencies.
H-13-040	Conduct an audit of the effectiveness of focused compliance reviews and upon the completion of the audit, require FMCSA to take action to resolve any safety issues raised by the audit.

¹ Of these motor carriers, 12,000 are passenger motor carriers.

² See Appendix 9 for the November 5, 2013 NTSB letter.

For the two motor coach crashes NTSB referenced (Mi Joo Tour and Travel crash in Pendleton, Oregon and Scapadas Magicas LLC crash in San Bernardino, California), it identified FMCSA oversight issues common to both companies. Both motor carriers were based outside the United States (Canada and Mexico, respectively) and received US operating authority from FMCSA. Neither company had a safety management plan, preventive maintenance program, or driver-training handbook. Neither company owned a garage for fleet maintenance nor had a mechanic on staff. Neither business had in-service driver training, and, in both cases, driver-training files were incomplete.³ Finally, driver drug and alcohol programs were non-compliant with regulations. Yet both companies received “Satisfactory” ratings on the Comprehensive CRs FMCSA conducted before the crashes. In one instance the CR was carried out 17 months prior to the fatal crash; in the other case just one month prior.

For the two crashes involving commercial property operations (Highway Star, Inc. in Elizabethtown, Kentucky and H&O Transport, Inc. in Murfreesboro, Tennessee), NTSB identified concerns about FMCSA’s Focused CRs. With both of these motor carriers, FMCSA did not uncover violations related to driver fatigue (hours of service) during the CRs conducted prior to the crashes.

1.2 Secretary of Transportation Calls for Independent Review

Secretary Foxx responded to the Chair of the NTSB on February 3, 2014, stating that he had directed the DOT Safety Council to oversee an independent review of FMCSA’s CR process.⁴ Secretary Foxx tasked the Federal Aviation Administration (FAA), as a peer of FMCSA within DOT, to conduct the review. FAA formed an Independent Review Team (IRT)⁵ for this purpose. The IRT includes a dedicated FAA executive with extensive intermodal safety expertise, FAA legal counsel with enforcement experience, and members who are independent from the DOT with backgrounds that are valuable to this review. The IRT members are:

William R. Voss (Chair)	Jacqueline A. Duley	Neil R. Eisner
Lynne B. Judd	William O. McCabe	Charles C.B. Raley

Secretary Foxx charged the IRT⁶ to determine:

- How investigators can more effectively identify violations of safety regulations by the motor carrier undergoing review;⁷
- How FMCSA quality assurance efforts can be more effective in assessing the accuracy and completeness of CRs;⁸
- What criteria determine whether a focused review is scheduled;⁹ and

³ FMCSA advised the IRT that some of these are not required under current law and therefore not a basis for enforcement.

⁴ See Appendix 9 for the February 3, 2014 letter from Secretary Foxx.

⁵ See Appendix 2 for biographical sketches of the IRT members.

⁶ See Appendix 10 for Secretary Foxx’s tasking letters to the IRT members

⁷ See Section 2.4 Compliance Review (CR) Process.

⁸ See Section 2.6 Quality Assurance/Quality Control—Investigator Performance and Policy Effectiveness.

- Who and what determines if a focused review is changed to a comprehensive review.¹⁰

Secretary Foxx further tasked the IRT to:

- Collect, analyze, and evaluate data collected from discussions with FMCSA headquarters and field personnel to develop appropriate recommendations for DOT's response to NTSB;¹¹ and
- Develop recommendations for other opportunities to improve motor carrier safety identified in the course of the IRT effort.¹²

⁹ See Section 2.4.1 Focused CRs.

¹⁰ See Section 2.4.1 Focused CRs.

¹¹ See Appendix 3 for a list of IRT interactions.

¹² See Section 2.0 FMCSA Safety Oversight of Motor Carriers and Section 3.0 Beyond a Compliance-Centric Enforcement Strategy.

2.0 FMCSA Safety Oversight of Motor Carriers

Through its “Safety Fitness Procedures” (49 Code of Federal Regulations [CFR] Part 385), FMCSA established a Safety Fitness Standard and procedures for assigning safety ratings to motor carriers operating in interstate commerce.¹³ To meet the Safety Fitness Standard, the motor carrier must demonstrate it has adequate safety management controls to reduce the risks associated with:

- Commercial driver’s license standard violations;
- Inadequate levels of financial responsibility;
- Unqualified drivers;
- Improper use and driving of motor vehicles;
- Unsafe vehicles operating on the highways;
- Failure to maintain accident registers and copies of accident reports;
- Fatigued drivers;
- Inadequate inspection, repair, and maintenance of vehicles;
- Transportation of hazardous materials, driving, and parking rule violations;
- Violations of hazardous materials regulations; and
- Motor vehicle accidents and hazardous materials incidents.

Since the Motor Carrier Safety Act of 1984, FMCSA’s rating process for motor carriers has been built upon the operational tool known as the CR. The CR was developed to assist federal and state safety specialists in gathering pertinent motor carrier compliance and accident information. It is the primary tool used by an investigator when conducting an on-site examination of a motor carrier’s operations to determine whether the carrier meets the Safety Fitness Standard. Because the CR is an in-depth examination of the motor carrier’s operations, all relevant documents, evidence of violations, available performance-related information, and reportable accident information is included. Regulatory noncompliance is considered indicative of breakdowns in the motor carrier’s management controls.

¹³ See Appendix 4 for additional information on FMCSA’s part 385 safety fitness requirements.

2.1 Compliance, Safety, Accountability Program

Over the last six years, FMCSA has undertaken a major initiative to improve the effectiveness of the Agency's compliance and enforcement programs, known as the Compliance, Safety, Accountability (CSA) program. This program seeks to achieve greater reduction in large truck and bus crashes, injuries, and fatalities, while using its own and the state partners' resources more efficiently. For a variety of reasons, the program is only partially implemented.

Additional expectations placed on investigators to perform better investigations, or cite more appropriate violations, will likely generate negative results unless the underlying dynamics are addressed.

Because the CR process is time intensive and FMCSA's workforce is limited compared to the 525,000 companies it oversees, the Agency and its state partners reach only a small percentage of motor carriers each year. FMCSA developed the CSA program not only to increase the effectiveness of its safety investigations but to expand its reach. There is evidence that contact during investigations of any kind encourages good behaviors and may improve safety. CSA consists of three components: (1) the data system, (2) the intervention process and (3) the Safety Fitness Determination rule.¹⁴

Data System—The data system is the Safety Measurement System (SMS), which uses all available roadside inspection and crash data to assist the Agency in prioritizing motor carriers for intervention. FMCSA uses SMS to allocate its resources toward the motor carriers with the highest crash risk. FMCSA analyzes violations of Federal Motor Carrier Safety Regulations (FMCSRs) discovered during roadside inspections, data gathered during CRs, and reportable crashes to measure a carrier's performance in seven Behavior Analysis Safety Improvement Categories (BASIC). The BASICS are: (1) Unsafe Driving, (2) Hours of Service (HOS) Compliance, (3) Driver Fitness, (4) Controlled Substances/Alcohol, (5) Vehicle Maintenance, (6) Hazardous Materials, and (7) Crash Indicator. The BASICS group FMCSR violations within these topical categories. With this data, FMCSA is able to prioritize motor carriers for an intervention in at least one BASIC for nearly 200,000 of the approximately 525,000 active interstate motor carrier or intrastate hazardous materials motor carriers for which FMCSA has safety oversight responsibilities. Based on FMCSA data, these 200,000 companies are represented in 91 percent of all crashes that involve a commercial motor vehicle.

Intervention Process—The intervention process uses a variety of tools, designed as part of CSA, to increase the number of carriers the Agency can reach with its limited resources. Prior to CSA, the CR was the primary intervention and investigative tool FMCSA used to induce compliance. It remains the mechanism to determine the safety fitness of truck and bus companies. The CR is time intensive and, in turn, limits the number of carriers with problem indicators that FMCSA can investigate. FMCSA now uses more tools to respond to a motor carrier's compliance and safety performance.

¹⁴ Statement of Anne Ferro before the House Committee on Transportation and Infrastructure Subcommittee on Highways and Transit, September 13, 2012.

These include warning letters, targeted roadside inspections, offsite investigations, cooperative safety plans, notices of violations (NOV), notices of claims (NOC), comprehensive and focused onsite CRs.

FMCSA developed the SMS to prioritize carriers for Divisions to assign CRs to investigators using on-road performance data, Congressional mandates,¹⁵ and FMCSA policies. At the time of assignment, each review is designated as either a *Comprehensive* or *Focused* CR. The Comprehensive CR requires a significant amount of time to review the documentation relevant to all the FMCSRs. A Comprehensive CR results in one of three safety ratings being assigned to a motor carrier—satisfactory, conditional, or unsatisfactory.¹⁶ A focused CR is limited to review of specific sub-categories of FMCSRs and may result in a downgrade of a carrier’s rating but not an upgrade to satisfactory.

Additionally, FMCSA is working to change the conduct of CRs from primarily an audit approach to an investigative approach that (a) identifies the root cause(s) of violations through identification of process break-downs, and (b) provides an educational element for the motor carrier to help improve the safety of its operation. To this end, the Agency has developed new training in Enhanced Investigative Techniques (EIT) and had delivered the training to more than three-fourths of the federal investigators at the time of the IRT’s report. Training of federal investigators is scheduled to be completed by the end of 2014, with training of state investigators to follow.

Safety Fitness Determination Rule—According to the Department of Transportation’s Significant Rules Report, the Safety Fitness Determination (SFD) rule that is currently in the rulemaking process would allow the Agency to adopt revised methodologies to make

The CSA system (which uses on-road performance data) and the legacy Safety Fitness Procedures (based on document reviews) are fundamentally disconnected. This disconnect will continue to affect investigators’ behavior until it is resolved.

Safety Fitness Determinations. The proposed methodologies could determine when a motor carrier is not fit to operate based on: (1) the carrier’s performance in relation to five of the BASICS; (2) an investigation; or (3) a combination of on-road safety data and investigation information.¹⁷ This rule is currently in development; thus the legacy Safety Fitness Procedures (49 CFR Part 385) continue to be used until a new rule is in effect.

The SFD rule will be controversial and even with expedited procedures it could still take several years to be implemented. In that interim period it is important that FMCSA examines the disconnect between CSA and the legacy Safety Fitness Procedures that impacts investigator behavior and take steps to resolve it.

¹⁵ Congress has mandated that FMCSA conduct comprehensive CRs for all passenger carriers at least once every three years and conduct at least 10,000 CRs per year in total across the motor carrier industry.

¹⁶ For additional details, see Appendix 4, Safety Fitness Requirements.

¹⁷ Department of Transportation [June 2014 Significant Rulemaking Report](#)

Two of the crashes that NTSB cited in making its recommendations to the DOT Secretary highlight the impact of this disconnect. It is best illustrated by comparing the BASICs used to prioritize motor carriers for Focused CRs and the BASICs violations that are cited during the course of these Focused CRs. The IRT believes that FMCSA has been successful in targeting high-risk carriers based on those carriers' BASICs scores, but has had great difficulty in citing violations of those same BASICs during the course of the Focused CRs, especially regarding BASICs with the highest correlation to crash rates.

For example, the HOS BASIC has been found to have a significant direct relationship to crash rates. In the 24 months prior to April 2014, in a total of 6,732 motor carriers prioritized for Focused CRs, 4,101, or 61 percent, of the total reviews involved motor carriers that exceeded policy-defined thresholds in the HOS BASIC at the time of prioritization. In these 4,101 Focused CRs, investigators cited a serious violation at the critical threshold in the HOS BASIC in only 23 percent of those Focused CRs.¹⁸

FMCSA is in the process of developing other metrics that will assess the relationship between the violations being written by the investigator and the safety behaviors being measured by the SMS. Over time these metrics should show a change in the pattern of violations that reflect decreasing investigator dependence on the legacy rule, better use of roadside information, and application of EIT.

As it is implementing these metrics, FMCSA should implement incremental policy changes, training programs, and other management actions that lessen investigators' dependence on the legacy Safety Fitness Procedures and move towards a more balanced and safety-aligned pattern of enforcement actions.

Recommendation 2.1.1

FMCSA should start addressing the disconnect between the CSA system and the legacy Safety Fitness Procedure while the new SFD rule is still being considered.

- a. Establish metrics that compare violations being written by the investigator with the risk predicted by the SMS.
- b. Implement and measure policy adjustments, training, and procedures intended to better align investigative outcomes with on-road risks.

Because the SFD rule is urgently needed to address disconnects within the CSA program, FMCSA should consider processes that are likely to expedite the development of an effective rule. This is especially important because of the delays that might arise due to controversy that could surround this rulemaking. There are approaches FMCSA could consider that may help expedite the rulemaking process and potentially improve the resulting rule. For example, FMCSA should continue to use facilitated public meetings and facilitated advisory committees. Facilitators should help the participants solve problems, bring out valuable information, and perhaps identify areas of consensus. Another example is negotiated rulemaking, which is a consensus building approach that

¹⁸ See Appendix 5 for FMCSA Analysis of Focused CRs.

might better identify effective solutions and significantly reduce controversy compared to the informal rulemaking process alone.

These types of approaches could also be expanded to include the ideas promoted in Recommendation 3.1 relating to cooperative development and coordinated implementation of voluntary safety programs. By addressing Safety Fitness Determinations in the context of voluntary safety programs, the agency might be able to more effectively identify ways to encourage involvement in voluntary programs without adversely affecting the effectiveness of the Safety Fitness Determination rule. For example, the motor carriers might be more willing to add a piece of safety equipment to their vehicles if they could be exempted from provisions within the rule the Agency determines would not be applicable or necessary with that equipment on the vehicles. Facilitated discussions could be much more effective than normal rulemaking procedures in identifying these areas of opportunity.

Recommendation 2.1.2

FMCSA should expedite the SFD rulemaking process and consider the use of consensus based, or facilitated, processes for the development of the rulemaking.

2.2 SMS Resource Prioritization for Motor Carrier Interventions

While FMCSA has a system for prioritizing its field resources for use against a group of high-risk carriers, it does not have a system that actively manages that risk once it has been identified.

The public should reasonably expect that every day FMCSA investigators focus their efforts on those carriers most likely to cause harm. The CSA prioritization system was intended to do that but the implementation needs to be improved. CSA methodology successfully identifies a large group of high-risk carriers and then assigns cases to the field. Once that assignment is made the system does not help

field management identify which specific carriers demand the most urgent attention and the group is too large for all identified carriers to receive attention at once. This problem underlies many of the NTSB and Congressional criticisms of FMCSA investigations, where it seems that obviously high-risk carriers were overlooked for months or those investigations ignored recent changes in the carriers' safety performance.

To be effective, FMCSA needs to be able to use all available data—whether derived locally or nationally and whether derived from CRs, roadside inspections or accident investigations—in order to manage risk in the system. This requires changes in management policies as well as increased decentralization of discretion. A meaningful, effective oversight and enforcement policy needs to be risk-based and agile enough to apply resources to the greatest risks. The IRT believes the number and prescriptive nature of internal policies and practices, combined with the accumulation of additional mandates imposed as a result of previous reviews, have become barriers to that end.

FMCSA analyzes violations of FMCSRs discovered during roadside inspections and CRs and data gathered from reportable crashes to measure a carrier's performance across the seven BASICs. Once a motor carrier's on-road data is over a policy-driven threshold in SMS, FMCSA assigns an intervention. The intervention may be an "early" intervention, such as a warning letter or a targeted roadside inspection. Alternatively, the intervention required may be an onsite investigation—either a Comprehensive or Focused CR. In this case, the motor carrier is placed in the existing queue of investigations for a specific Division. FMCSA policy then permits up to 12 months for an investigation to be completed.

The investigation queue for any Division may include numerous congressionally-mandated investigations, FMCSA policy-driven investigations, and those identified via SMS. If there is a significant backlog of nearly-due or overdue investigations, the Division manages the workload primarily as a first-in-first-out production model and no longer as a risk-targeting application of resources.

Risk is dynamic and a motor carrier's performance as measured by SMS may change over the up-to-12 month period before the investigation is initiated. Of the 7,361 motor carriers that SMS prioritized in CY 2013, roughly 27 percent had additional BASICs go above threshold during the period between CR assignment and time of review.

Conversely, nearly 33 percent had a BASIC above threshold when assigned that was no longer above threshold at the time of the review. To further this point, the case studies highlighted by NTSB clearly demonstrate the importance of monitoring the trajectory of BASICs post-CR-assignment by SMS.

To more effectively target the “worst of the worst” FMCSA should consider modifying the current queuing approach so that it can respond quickly to carriers whose safety performance degrades after a CR is assigned. This is the case in the 27 percent of carriers who have additional BASICs go above threshold after a CR is assigned. Since the beginning of CSA, it has taken FMCSA on average nearly six months to complete CRs of carriers after additional BASIC alerts were noted. In 2013, FMCSA took, on average, nearly three months to respond to the same escalation. By continuously reviewing the status of carriers and reprioritizing reviews in response to degrading carrier performance, FMCSA could target risk in a measurable and objective manner. Within the Agency, an understanding of motor carrier performance trends should inform field actions, especially when investigation backlogs are long and real motor carrier performance degrades.

Recommendation 2.2.1

FMCSA should sharpen its priority-setting focus and improve the timeliness of investigator actions on those motor carriers representing the highest risk.

- a. Modify the selection formula and policies to limit the number of mandatory and other non-risk-based high-priority candidates.
- b. Seek or create relief from internally and externally generated mandates for CRs involving carriers of lower risk.
- c. Reprioritize reviews of motor carriers whose safety performance degrades after an investigation is assigned.

FMCSA’s existing use of data reflects centralized directives to the field (control) in advance of investigations rather than enabling ready access to data for in-depth analyses of motor carrier risk profiles. For FMCSA to achieve its CSA-related goals and objectives, it will need to consider shifting from using data as a centralized directive or control function to one that informs each Division and investigator in the assessment of risk and allows for discretion. A more appropriate headquarters use of data is to evaluate the outcomes achieved by the divisions and provide feedback. In a data-enabled environment, the Division Administrator and investigator prioritize across their known risk pool. The investigators may use the data to become better informed on the historical behaviors of a motor carrier and therefore determine if a pattern of risky behavior exists. Such a pattern may warrant an immediate intervention. Contrast this prospect with the current reality, where the type of review done is determined by a central analytic function in headquarters and the primary job of an investigator is to comply with prescriptive policies governing Comprehensive and Focused CRs.

When FMCSA identifies a motor carrier as high-risk and assigns a CR, it implicitly assumes some level of accountability for the risk that the motor carrier poses to the

public. Every month that passes prior to the initiation of a scheduled CR increases the risk that the motor carrier will be involved in a crash before FMCSA takes action that might prevent it. By examining the number of motor carriers assigned CRs and the average time it takes for FMCSA to complete them, it is possible to create a picture of where this implicit risk resides.

The IRT observed that FMCSA's risk exposure is not evenly distributed across the 52 field Divisions.¹⁹ The vast majority of this lag-related risk resides within a relatively small number of Divisions. FMCSA needs to focus additional resources on these offices to create a more balanced distribution of this risk. Additionally, in these critical Division offices, Division Administrators must be allowed some level of authority and accountability to triage a vast pool of potential risk. In essence, FMCSA should allow for risk-based use of discretion (producing rational inconsistencies across Divisions) within established parameters to improve risk management. There is also merit to applying a layer of local knowledge about motor carrier operations and to setting priorities based on that local knowledge. Exercise of such decentralized risk-analysis requires enhanced analytical capabilities at the local level, something that FMCSA has started to develop. Centralized monitoring systems would nevertheless allow headquarters to evaluate outcomes being achieved in each Division and Region (rather than perpetuating the current emphasis on activities and production quotas). Over time, the agency would embrace more sophisticated notions of quality assurance in their risk-control operations, and, with time, apply them across the Agency.

Recommendation 2.2.2

FMCSA management should act quickly to review resource allocation across Regions and Divisions to better align appropriate resources to the location of highest risk.

- a. Better balance Agency resources against the existing geographic pools of risk.
- b. Provide Division Administrators with the highest risk exposure with analytical capability, authority, and accountability to manage the pools of risk.

¹⁹ See Appendix 6.

2.3 SMS Data

The CSA program has ignited a debate across the industry regarding the appropriate use of safety data. If this debate is not refocused, it will stall the adoption of safety practices that are needed by the industry and expected by the public.

There is considerable controversy and debate over the efficacy of SMS data. This controversy must be addressed so that resources can be focused on improving safety instead of arguing data points and to enable successful promulgation of a new SFD rule. It is important for FMCSA and its stakeholders to find more effective ways to engage in and resolve this debate.

FMCSA's fundamental premise in CSA is that high percentile scores in a BASIC indicate a lack of compliance and exposure to potential safety problems, including crash involvement; as scores go up, actual crash involvement increases.

In an August, 2011 report, FMCSA and the University of Michigan Transportation Research Institute (UMTRI) presented their evaluation of CSA's operational test model pilot program, conducted from February 2008 through June 2010. Their results showed that SMS was a significant improvement over its predecessor in identifying unsafe carriers. For all BASICs, crash rates were higher for carriers exceeding SMS thresholds than for carriers not exceeding thresholds. The crash rate was highest for carriers exceeding the Unsafe Driving threshold.

In October, 2012, the American Transportation Research Institute (ATRI) presented their analysis of the relationship of BASICs scores to crash risk. The analysis revealed:

- Carriers with an "Alert" in one or more of BASICs for Unsafe Driving, Fatigued Driving, Vehicle Maintenance, and Controlled Substances and Alcohol demonstrated higher crash rates than carriers without an alert status.
- Carriers with an "Alert" in the Driver Fitness BASIC actually had *lower* crash rates than those without an "Alert" status.

In February, 2014, the U.S. Government Accountability Office (GAO) issued a report²⁰ recommending FMCSA revise the SMS methodology in CSA to better account for limitations in drawing comparisons of safety performance information across carriers. In addition, GAO recommended that a determination of a carrier's fitness to operate should take into account limitations in available performance information.

In March, 2014, the DOT Inspector General (IG) issued a report²¹ finding that FMCSA has strengthened its controls to improve the quality of state-reported data used to assess

²⁰ *Federal Motor Carrier Safety Modifying the Compliance, Safety, Accountability Program Would Improve the Ability to Identify High Risk Carriers* (GAO-14-114). GAO was directed by the Consolidated Appropriations Act of 2012 to monitor the implementation of CSA

²¹ *Actions Are Needed To Strengthen FMCSA's Compliance, Safety, Accountability Program* (MH-2014-032). In October 2012, the Chairman and Ranking Member of the House Transportation and Infrastructure

carriers' safety performance, but the Agency has not fully implemented planned process improvements for reviewing data correction requests and ensuring that the information motor carriers are required to submit every two years is accurate. In addition, the IG found FMCSA has not fully implemented the CSA enforcement intervention process nationwide; and that FMCSA has limited documentation demonstrating that it followed information technology system best practices and federal guidance while developing and testing SMS. The IG made six recommendations to strengthen CSA's data controls, address intervention challenges, and improve system documentation. According to FMCSA, it has already resolved three of the six recommendations in the IG's report.

FMCSA has responded to criticisms of incomplete and missing information on the number and type of motor carriers regulated. The Unified Registration System (URS) is a new electronic on-line system the industry will be required to update biennially. URS is a consolidation of: (a) USDOT identification number system; (b) proof of insurance system; (c) Federal operating authority; and (d) process agent designations. The Agency issues a warning letter 30 days in advance of a biennial update deadline to notify the entity that its USDOT Number is deactivated if it fails to comply with the biennial update requirement. To date, FMCSA reports that it has deactivated over 60,000 US DOT numbers based on a motor carrier's failure to submit a biennial update.

FMCSA has also responded to issues around the quality of data used in FMCSA data-driven safety systems. The State Safety Data Quality (SSDQ) program was created to improve the quality of data provided by the states that is used in SMS; New Applicant Screening (NAS); Inspection Selection System (ISS); Driver Information Resource (DIR); and Pre-Employment Screening Program (PSP). For example, FMCSA has recently announced a new policy to allow drivers or motor carriers to request that results of State Court adjudications be reflected in FMCSA's data systems.

The IRT does not assert any expertise in this area but has observations that may be useful in calming the debate. Today, the data is organized around the chapters that make up the FMCSRs, intermingling procedural and management issues with behaviors most directly connected to crash risk. The system may be more effective if the data is re-organized to give the appropriate attention and importance to compliance with regulations that foster good overall safety management, and to behaviors most directly and immediately influencing safety. The "form and manner" compliance issues should not be mixed in with the crash risk-related violations in each BASIC.

To separate the form and manner violations from the violations that have a direct impact on crash risk, FMCSA could create a "grouping" of compliance-specific BASICs as "management controls," and use it in conjunction with the current BASICs. Alternatively, it could consider creating an eighth BASIC with the same purpose. Either approach could help distinguish between carriers evidencing management issues that may lead to safety problems and those that demonstrate high-risk behaviors that are directly and immediately connected to crash risk.

Subcommittee on Highways and Transit requested that the IG evaluate FMCSA's CSA program. The objectives were to assess FMCSA's data quality controls and its enforcement intervention mechanisms.

Recommendation 2.3.1

FMCSA should expand its work with industry and stakeholders to develop SMS enhancements. These enhancements should enable FMCSA to better discern motor carrier management actions that lead to crashes and to allow more timely and appropriate investigation and enforcement actions.

There is concern in the industry about the transparency of the BASICs information and its effect on the reputations of their businesses. Throughout society, however, consumer and public protections are being enhanced in many other areas through increased use of public transparency and dissemination of safety ratings and assessments. Availability of such data informs the public and helps them make better choices. Poor performers suffer in the marketplace, and better performers gain market share. The government—if it is the party releasing the data—has the obligation to ensure data quality. Safety ratings should obviously be a fair reflection of a motor carrier’s operation; and the more accurate they become the more useful they will be in informing public choice and enhancing safety. Because many stakeholders (e.g. shippers, insurers, and litigants) assume SMS data reflects safe versus unsafe operations, FMCSA should take steps to clearly identify for the public the information that can be tied reliably to safety; and to distinguish it from other information that may be useful for other reasons but does not relate to crash risk. FMCSA proposed display changes in a November 5, 2013 Federal Register Notice.²²

One area where there is broad agreement among investigators and motor carriers is that both groups believe the use of *relative* SMS percentile threshold scores may be causing more problems than it solves. The relative SMS percentile ranks motor carriers based on their SMS score relative to their peers. In this system, it is possible for a motor carrier’s rating to rise or fall based on the actions of its peer carriers and may be unrelated to any action by the rated carrier. For the investigators, the relative nature of the BASIC scores makes it difficult for them to discern if changes in percentile scores are occurring because of: (a) aging of violations; (b) changes in the peer group’s performance with no change in operator performance; or (c) real changes in a carrier’s operating performance. For the motor carrier, the IRT found that the relative scoring actually can discourage the sharing of leading safety practices because any increase in the score of a peer may result in a reduction in the relative rating of the motor carrier that shares it. It is possible the competitor subsequently achieves a better percentile score while the first carrier’s own relative rating decreases without any actual change in safety performance.

Achieving long-term improvement in operator safety depends on the community developing, sharing, and adopting leading safety practices. The IRT believes FMCSA’s data has a major role to play in that regard but providing relative SMS ratings may stifle such innovation and sharing.

FMCSA management recognizes the issues associated with relative ratings. The IRT encourages development of an approach that, at a minimum, emphasizes factual, absolute

²² *Proposed Enhancements to the Motor Carrier Safety Measurement System (SMS) Public Web Site*; 78 FR 66420.

data. This data belongs to the public, and the public will ultimately decide how to use it. Businesses are already emerging that use sophisticated analytical techniques to turn this data into reliable management information. This trend is inevitable, and it will ultimately re-shape the marketplace. FMCSA will need to reconsider its role in this rapidly emerging environment, possibly shifting towards providing objective data rather than ranking motor carriers. Whatever role FMCSA assumes in this data-rich environment, it should work to ensure its data, analysis, and policies do not discourage industry from sharing best practices and from assuming more responsibility for safety performance.

Recommendation 2.3.2

FMCSA should re-assess its current SMS website.

- a. Continue to identify and implement methods for emphasizing absolute rather than relative individual motor carrier rankings so that it does not undermine industry's willingness to innovate and share best practices.
- b. Consider the role it will play in dissemination of safety information as the motor carrier industry matures

2.4 Compliance Review (CR) Process

During its post-crash investigations, NTSB uncovered FMCSR violations investigators had not identified during the pre-crash CRs for each of the motor carriers referenced in its November 5, 2013 letter to Secretary Foxx—whether the CRs were Comprehensive or Focused. NTSB believes the investigators should have identified

these violations and taken enforcement action that might have prevented these crashes. Through its review, the IRT found that (a) investigators are challenged in citing some types of violations due to internal policies and practices; (b) time pressures exist that influence the investigators' thoroughness in conducting CRs; (c) there is insufficient training for investigators in identifying specific violations in areas such as vehicle maintenance; and (d) there are few opportunities to inspect vehicles as the most revealing inspections are those that are conducted when the vehicle is in transit.

FMCSA is taking measures to improve the quality of their investigations. However, the investigations currently do not consistently result in cited violations that target the highest risk behaviors.

The IRT believes that FMCSA's policies and established practices make it difficult for investigators to write certain violations in the context of a CR. For example, for an investigator to make a case related to unsafe driving,²³ the investigator must find evidence of a prescribed number of violations²⁴ related to the drivers' performance while operating for a particular motor carrier. The investigator may find some evidence of unsafe driving practices with the motor carrier (perhaps documentation of driver speeding tickets) but it may not be sufficient to make a case for enforcement, even though these behaviors are known to correlate to crash risk.

This issue is best illustrated by the number of times that Focused CRs are assigned with certain targeted violations of the FMCSRs versus the number of times that investigators cite the same targeted violation following their investigation. For example, in the 24 months preceding April 2014, 2,022 Focused CRs were assigned targeting violations related to unsafe driving, which has been found to have the highest correlation to crash rates. For these Focused CRs, investigators were able to cite violations at the critical threshold (10 percent violation rate) related to unsafe driving regulations in four (0.20 percent) of the investigations.²⁵

In contrast, the IRT has been told it is much easier to write violations on the form and manner of logs, driver fitness, and similar FMCSRs. While these are safety regulation violations, they are not the types of violations that have been shown to directly or

²³ 49 CFR 392.2 requires every commercial motor vehicle to be operated in accordance with the laws, ordinances, and regulations of the jurisdiction in which it is being operated.

²⁴ 49 CFR Part 385 defines a pattern as more than one violation. When a number of documents are reviewed, the number of violations required to meet a pattern is equal to at least 10 percent of those examined.

²⁵ See Appendix 5 for FMCSA Analysis of Focused CRs.

significantly correspond to crash risk. Similarly, in the 24 months preceding April 2014, 521 Focused CRs were assigned targeting driver-fitness violations, which has been found to have a low, or even inverse, relationship with crash rates. In these 521 Focused CRs, investigators were able to cite critical violations of driver fitness regulations in 148 (approximately 28 percent) of the investigations.²⁶

The IRT found FMCSA investigators want their work to make a difference when they believe they have identified an unsafe motor carrier. Investigators emphasize safety fitness procedure citations because these are the ones that will most impact the motor carrier. For example, for non-hazardous material motor carriers, out of hundreds of FMCSRs, there are a handful of violation types recognized as “critical and acute.” However, the list of “critical and acute” violations is dated and scheduled to be replaced in future rulemaking. The current list, for example, does not include some types and patterns of violations now recognized as reliable indicators of crash risk. If an investigator writes enough “critical and acute” violations, a well-worn set of processes are triggered resulting in a downgrade of the motor carrier’s safety rating in the Safety Fitness Procedures. Should an investigator stray outside that construct, such as citing non-critical or non-acute violations, he or she may develop a NOC or NOV, but it would have no impact on the safety rating. These are much more difficult to substantiate using the Agency’s legacy tools and may have less of an impact on the motor carrier. The IRT believes most investigators therefore choose those actions that will affect the motor carrier’s rating whenever the totality of what they see warrants enforcement action.

The IRT believes investigators are under time pressures that negatively influence the scope and thoroughness of the CRs. Investigators have performance targets of four to five CRs per month. The IRT was informed that this requirement has been removed through recent policy directives and the change is being reinforced in the EIT training. However, training of federal investigators will continue through the end of 2014, with training of state investigators to follow. In addition, the IRT has been advised the performance metric still exists in the formal investigator performance plans. Moreover, FMCSA has not yet developed alternative metrics addressing quality or completeness of reviews to replace the four to five CRs per month target.

FMCSA relieved some of the time pressure on investigators during the 2013 Operation Quick Strike Task Force when it permitted investigators to have more time for reviews.²⁷ FMCSA assigned investigators who had completed EIT training to the Task Force. The preliminary results indicate that EIT, plus removing time constraints, plus allowing for expansion of the scope of investigation has increased the number of cited violations that correspond to crashes. Serious violations were cited five times more often during Quick Strike than during a 2012 Task Force.²⁸ The “acute and critical” subset of these serious violations were cited six times more often during Quick Strike and resulted in a greater number of unsatisfactory safety ratings compared to the 2012 Task Force.

²⁶ See Appendix 5 for FMCSA Analysis of Focused CRs.

²⁷ See Appendix 7 for a detailed timeline of these events.

²⁸ The FMCSA Passenger Task Force Analysis Phase I report compares the Quick Strike activities of 2013 (April – October 2013) with those conducted in 2012 (August – September 2012). Additional analyses in Appendix 8.

It is too early to determine the long-term effects of EIT on the number and type of violations cited for all CRs, but the preliminary results of the Quick Strike Task Force are promising. FMCSA intends to benchmark this analysis for all federally conducted CRs over the past three years and use it as one possible measure of CR quality.

2.4.1 Focused CRs

Given limited resources and an increasing demand for investigations, FMCSA created the Focused CR to more efficiently and effectively use resources at the motor carrier's place of business. In advance of a Focused CR, the investigator is provided with information about the motor carrier's recent (two years) safety record and is directed to focus on specific areas for which the motor carrier has shown some pattern of non-compliance (e.g., HOS or vehicle maintenance). The underlying assumption is that if an investigator knows where to look first for non-compliance issues, particularly those with a high correlation to crash risk, the investigator can more quickly determine whether the motor carrier's regulatory violations require administrative action or enforcement action.

As described earlier, the NTSB identified concerns about FMCSA's Focused CRs conducted at the two commercial property motor carriers prior to the crashes. In both cases, FMCSA did not uncover violations related to HOS. At the time of the Focused CRs, the investigators targeted violations related to unsafe driving. The IRT found the investigators' actions during a Focused CR are influenced by the on-road performance data available at the time and the investigators' understanding of whether they are permitted to broaden the scope of the investigation beyond the targeted areas.

The NTSB recommended the Secretary of Transportation conduct an audit of Focused CR effectiveness. The IRT found that given the current state of implementation, it was not possible to fully assess the effectiveness of Focused CRs using a conventional audit process; FMCSA has altered the guidance governing these reviews over time and has a limited amount of evaluative data available, partly owing to reliance on legacy data systems. Thus, the IRT was unable to establish a baseline and a current state that could be compared. However, the IRT made a concerted effort to understand how the policies governing Focused and Comprehensive CRs impacted investigator actions.

The IRT found that implementation of Focused CRs brought significant problems in the investigative process to the surface that had always been present, but had previously been masked by the broad scope of the original CR. As explained in Section 2.1 and illustrated in Appendix 4, the investigative rules and policies governing all FMCSA CRs make it difficult for investigators to write violations in certain areas. If the investigator is asked to conduct a Focused CR on these specific areas, the investigator will most likely be hampered. An investigator completing a Comprehensive CR faces the same challenges in certain areas, but is able to move on to violations in other areas that are more easily written.

Further complications arise when the on-road performance data that FMCSA uses to prioritize a motor carrier for review changes between the time when SMS indicates a motor carrier requires intervention and when the investigator conducts it. In CY 2013, nationwide, there was an average of nearly three months between the time of the

assignment and the time the CR was conducted, with considerable variation in the lag time among states. During this delay the on-road performance data may change, indicating to the investigator additional areas that may warrant attention or, conversely, that the original indications of risky behavior are no longer above a policy-driven threshold and therefore no longer require attention.

The IRT observed that Focused and Comprehensive CRs *both* place significant constraints on the investigator with respect to the scope of the review. In a Comprehensive CR an investigator is expected to look at everything, even if the investigator understands immediately that the motor carrier is compliant in particular areas. The investigator is not allowed to limit the investigation even when it is logical to do so. Conversely, in a Focused CR the investigator is expected to limit the review to certain areas. If the investigator finds evidence of problems in other areas, the investigator is not currently allowed to act on that information unless he or she gets express permission to expand the investigation. In both cases, the investigator is not allowed to use his or her judgment or discretion in acting on the information available at the site.

FMCSA is communicating a change in policy and encouraging investigators to request permission to adjust the scope of their reviews as necessary to adapt to what they see onsite. This policy is reinforced during EIT training along with the policy change removing the target of four to five CRs per month. The IRT interviewed investigators during and after EIT training. These investigators clearly understood that they were now authorized to expand a Focused CR with the approval of their division's Federal Program Specialist (FPS). For example, an investigator may be assigned a Focused CR based on a motor carrier exceeding thresholds for factors related to HOS and unsafe driving. A few months may lapse before the investigation, in which time the operator may then exceed the thresholds in factors related to vehicle maintenance, while HOS may have decreased to below the threshold. Per FMCSA policy, investigators are directed to focus on those areas above threshold at the time of assignment and must request permission to adjust the scope of the investigation to include other areas if necessary based on initial findings while onsite. Many investigators interviewed, however, were skeptical that scope requests would be welcomed or approved given the time pressures to clear the backlog of investigations in a Division's queue. Given the potential for investigators to continue working to achieve an outdated performance management "quota" for numbers of CRs, FMCSA should improve its "quality" message penetration through training and Division Administrator leadership effectiveness.

Recommendation 2.4.1

FMCSA should ensure that the "quality over production" priority is clearly and consistently reinforced in its training programs and emphasized through Division Administrator guidance to the investigators.

2.4.2 Moving from Data-Constrained to Data-Enabled CRs

There is considerable debate around the appropriate use of Comprehensive and Focused CRs. As noted earlier in this report, the IRT sees this as a choice between two sets of constraints, both of which attempt to generate consistency by limiting investigator discretion. It may be appropriate for FMCSA and its stakeholders to consider a fundamentally different choice. Rather than using SMS data to decide which policy should be used to constrain investigator actions, FMCSA should consider how data can be used to inform investigator actions and how quality reviews can be used to evaluate the use of investigator discretion.

Investigators should be provided with guidelines suggesting an investigative approach based on the motor carrier's SMS profile and history. These guidelines may suggest focusing on a single BASIC, all the BASICs, or some number in between, but they should primarily serve as starting points. Once the investigators go into the field, they should be expected to consider all of the information available at that time and make appropriate adjustments to the scope of their inquiry during the course of the investigation. In exchange for this flexibility, the investigators would be expected to document the reasons they chose to increase or decrease the scope of the investigation. This rationale, along with investigative outcomes, would be routinely reviewed by management at the field offices.

Such an approach would effectively erase the distinction between Focused and Comprehensive CRs, replacing them instead with data-informed, quality-assured reviews. This change could occur incrementally through an easing of policy guidance; continued training and development; and concurrent application of quality controls. Such a shift would require the support of Congress and other stakeholders who currently adhere to the belief that *comprehensive* CRs equate to *quality* reviews.

Recommendation 2.4.2

FMCSA should enhance its processes:

- a. Modify the CR “Comprehensive and Focused” distinctions in favor of a data-informed spectrum of CRs.
- b. Provide Division Administrators and investigators discretion to determine the level and scope of a CR.
- c. Establish regular reviews and feedback processes to ensure consistency and quality.

2.5 Enforcement of FMCSR Compliance

During the conduct of a CR, the investigator is charged with evaluating why safety problems are occurring, suggesting remedies, encouraging corrective action(s), and, where corrective action is inadequate, invoking strong penalties. The penalties are implemented through enforcement actions.

FMCSA has sought, and been granted, additional enforcement authorities. However, the agency needs to further improve its enforcement policies and procedures to take better advantage of these authorities.

As noted earlier, the IRT found the disconnect between the on-road performance data system and the legacy Safety Fitness Procedures complicates the

investigator's role, which makes enforcement actions more difficult. In particular, the IRT observed considerable confusion in the field about whether some BASIC data can be used to support an enforcement action. The major concern centers on unsafe driving BASIC data, which is a strong predictor of future crashes. Data shows investigators cited violations of FMCSRs related to unsafe driving at the critical threshold in only 0.20 percent of the Focused CRs in which the unsafe driving BASIC was above threshold at the time of prioritization.²⁹ Almost all of the investigators the IRT met with did not believe they could use evidence such as multiple speeding tickets to establish a pattern of unsafe driving violations because it might be seen as a type of "double jeopardy" for enforcement to occur against both the driver and the carrier.

Another problem the IRT identified is that investigators believe they must collect extensive information to support an enforcement action. Combined with the time constraints already discussed, it appears that investigators sometimes ignore violations that may relate to crash risk, instead citing violations that, although less serious, are easier to document and readily enable successful enforcement. The investigators believe this achieves the necessary result—enforcement action against a motor carrier engaging in unsafe behavior. Many of the industry representatives the IRT met with, however, complained that while they supported the CSA program as a valuable tool for identifying unsafe motor carriers, they are disappointed in its implementation. They believe it has created "gotcha" investigators who are simply looking for ways to penalize the motor carriers, and that the Agency has become more compliance-oriented than risk-focused.

Recommendation 2.5.1

To allow more effective use of Agency resources, FMCSA should clarify or modify its guidance on when it is appropriate for investigators and enforcement attorneys to take enforcement actions.

- a. Develop guidance to clarify that BASIC data may be used to establish a basis for enforcement actions against patterns-of-behavior violations, such as frequent speeding citations across a carrier's driver population.

²⁹ See Appendix 5.

- b. Examine current guidance on the required documentation in a CR, such as number of violations necessary to support an enforcement action, to determine whether the guidance can be changed to increase the focus on accident prevention without adversely affecting the likelihood of an enforcement action being sustained.

FMCSA has invested, to good effect, in expanding its set of enforcement tools. This work needs to continue and is especially important in the absence of a new SFD rule. It has worked to expand its use of Imminent Hazard determinations and might consider, for example, whether “ticketing” programs, such as the one used by another DOT agency, Pipeline and Hazardous Material Safety Administration (PHMSA), might be effective for FMCSA. This approach might streamline administrative procedures, cut costs, and reduce burdens on regulated entities. Such programs are used to issue tickets for violations that have little or no direct impact on preventing future incidents (e.g., inadvertently forgetting to include information in a required record). The agency imposes a reduced penalty for those who elect to pay the ticket amount rather than challenge the enforcement action.

While the Imminent Hazard out-of-service order is an important and effective enforcement tool available to the Agency when it is clear that a motor carrier represents a danger to the public, there is a potential problem. When such an order is challenged by the affected carrier, there is a statutory requirement that review of the order must “occur not later than 10 days after issuance of” the order, presenting a significant obstacle to the successful use of this enforcement tool. This requires clarification or modification.

Another area that FMCSA should clarify, as it considers expanding its range of enforcement tools, relates to the conduct of the investigations themselves. The IRT heard complaints about the lack of available enforcement tools to penalize carriers who do not appear for scheduled investigations, sometimes on multiple occasions. This frustrates the investigators and wastes Agency resources. It is important to remember that, while CSA offers an array of interventions, not all of them are performed onsite. The reason for going to the motor carrier’s place of business is to gather additional information to determine whether the motor carrier is in compliance. The central analytic function alone does not have sufficient information to determine this. The job of the investigator is to supplement the SMS data from roadside inspections, other CRs, and crashes with information gathered on-site that can help the Agency determine whether enforcement action is necessary. Addressing process violations, such as failure to appear for scheduled investigations, could save Agency resources as well as provide early identification of problem motor carriers.

Recommendation 2.5.2

FMCSA should expand or improve its enforcement tools.

- a. Identify more effective tools for handling relatively minor violations.
- b. Ensure a common understanding Agency-wide of tools to penalize motor carriers that commit process violations such as failing to appear for scheduled investigations.
- c. Clarify or, if necessary, seek statutory modifications to address the problems created by the deadline for the opportunity to review imminent hazard out-of-service orders.

2.6 Quality Assurance/Quality Control—Investigator Performance and Policy Effectiveness

A challenge that organizations commonly face is how to truly enable the work force to do their jobs with the right balance of management direction and employee discretion and authority, and to provide measures of accountability for both. This can be particularly difficult during times of change. FMCSA faces that challenge with its CSA program. Headquarters' managers, in the midst of developing and implementing internal initiatives, are simultaneously trying to be as responsive as possible to various external pressures.

In an effort to achieve consistency across the field, FMCSA relies heavily on prescriptive rules and procedures to control behavior instead of using a balanced approach that permits greater use of field-level discretion and uses a quality assurance approach to examine, after-the-fact, judgments made and actions taken.

The IRT believes that FMCSA managers have in the past tended to distribute prescriptive policies and procedures to the field, sometimes in haste and therefore with less than full staff consultation. The Agency does not appear to have or regularly review metrics on the effectiveness of its enforcement tools in changing crash-related behaviors. Without such metrics, the Agency is unable to focus resources on using its most effective tools or to reconfigure tools that are not meeting the Agency's goals. It is especially important to address this issue in the absence of a SFD rule completing implementation of the CSA program. More inter-office harmonization with the field on the front end, coupled with more evaluative feedback to the field on the back end, may improve the appropriateness of guidance disseminated and adopted.

Much of the job of today's investigator is defined in the electronic field operations training manual³⁰ (eFOTM) and other policies. Its purpose is to establish a consistent, uniform, and defensible process across the Agency. The guidance and associated policies are prescriptive in nature. This results in (a) investigators having little discretion to make decisions regarding risk or the safety of an operation; and (b) a production performance model where the number of investigations is more important than the quality or effectiveness of addressing risk in the system. Without a quality assurance process to ensure investigator performance, it is difficult for leadership to address inconsistent performance among investigators.

FMCSA needs to move towards the use of quality assurance and quality control methods. Quality processes will reduce the need for prescriptive direction to the front line and instead manage investigators' use of discretion and the professional judgments they make. The IRT's recommendations address ways in which the Agency can improve its headquarters/field interaction and therefore, its managerial and operational effectiveness. Structured coordination may make the environment less frenetic and yield better

³⁰ FMCSA's electronic Field Operations Training Manual (eFOTM) is an extensive guidance document for the conduct of investigations. It also provides guidance regarding the necessary and sufficient information for enforcement.

predictability for policy consistency, communications clarity, strong risk-based field level execution, and overall enforcement effectiveness.

There are several definitions of quality, but in general they all include the ability of a set of inherent characteristics of a service or process to meet the desired objectives. Quality assurance activities support high-quality investigator performance by providing staff and management at all levels visibility into, and feedback on, processes and associated work performance throughout the CSA program. The value of the quality assurance process goes beyond the near-term benefit of resolving noncompliance. A designated office or “quality team” compiles and evaluates the results of multiple audits of a process to identify root causes of noted non-compliance and to identify trends in process execution over time. The quality team also identifies significant changes—both positive and negative.

In interviews and site visits, the IRT identified several FMCSA Divisions that have initiated quality-related practices that are a good start for the Agency in this area. These divisions review, by individual investigator and across the Division, the areas of investigation; the violations cited; and whether sufficient information was provided to support an enforcement action as well as explain any deviation from the original scope of investigation. These Divisions learn through these analyses whether they need to provide additional investigator training and testing or refresher training in specific areas.

Recommendation 2.6.1

FMCSA should:

- a. Establish routine quality reviews of CR processes and outcomes by Division Administrators in each state such as those applied during 2013 Quick Strike.
- b. Create a mechanism by which practices and outcomes across divisions and regions are reviewed to identify best practices, problem areas, and patterns that indicate training may be needed.
- c. Perform consistent, detailed, headquarters evaluations of enforcement effectiveness—by enforcement tool, by division, and by case/investigator; use the analysis to provide regular feedback to divisions and regions about their effectiveness and to inform Agency adjustments to policies and expectations.

2.7 Partnering with the States

The FMCSA employs approximately 1,100 people. It meets the range of its responsibilities through partnerships with state and local grantees that employ more than 12,000 safety professionals. Each year state and local grantees conduct more than 3.4 million of the 3.5 million CMV roadside inspections; more than 34,000 of the 38,000 new entrant safety audits; and more than 6,000 of the 16,000 CRs.

Partnerships between FMCSA and States are critical for effective CMV safety enforcement. Each can gain from stronger relationships.

FMCSA helps fund state commercial vehicle enforcement programs via Motor Carrier Safety Assistance Program (MCSAP) grants. Each state has an annual plan to use the federal funding and its matching funds, in which it commits to a level of effort. Consistent with recent practice for FMCSA's own investigators, the assigned level of effort seems to be defined in terms of activity levels rather than outcome goals. In most or perhaps all states, MCSAP funding supplements state funding of CMV enforcement efforts, and represents varying proportions of total commercial vehicle activity from state to state. FMCSA's management reach to state-employed personnel is very limited.

The IRT met with or received input from representatives of more than a dozen states and based the following comments on that input, coupled with FMCSA management discussions:

- Decision processes in one bureaucracy may not be transparent to the other party(ies).
- States do not seem to know/understand how FMCSA makes certain decisions (e.g., why specific CRs are assigned).
- Federal managers may not know/understand/have access to dynamics that control priorities for state-based personnel.

State personnel are also involved in training inspectors and investigators in their own states and as part of teams with federal personnel. It appears that training of federal and state investigators occurs separately, which may represent a missed opportunity to share experiences, best practices, and expectations. As with many issues in this report, FMCSA management seems to recognize some of these issues and has begun looking at how to address them, including beginning discussions on a single curriculum for state and federal inspectors and investigators.

A number of the state enforcement representatives with whom we met expressed concern over the equality of the relationships with their FMCSA partners. This surfaced primarily during conversations involving the CR process, in which both federal and state investigators participate. While the perspectives were mostly voiced by those at the program level, the IRT believes this may be a good time for the Regional and Field Administrators to personally confirm with their respective Division Administrators that

“partnering” in the FMCSA-state relationships remains strong, respectful, and focused on a mutually shared understanding of the mission.

There are many legitimate reasons why relationships with state partners could vary greatly. They include differences in political leadership and chains of command; local priorities; total staffing levels that constrain contributions; knowledge base and skill sets even among those doing similar work; and personalities. All relationships, however, should be open, cordial, professional, and committed to making the most of whatever situation prevails. The feedback we received suggests opportunities for improvement may exist in some areas.

Recommendation 2.7.1

FMCSA should lead a joint federal/state initiative to assess the quality and effectiveness of the partnership working level relationships, followed by developing specific measures as required to ensure the partnership working environments remain consistent with the respective senior leadership expectations.

3.0 Beyond a Compliance-Centric Enforcement Strategy

Clearly, the FMCSA is working diligently to improve its system of compliance and enforcement to get unsafe operators off the road before they crash. Congress, NTSB, and others actively support those initiatives. At the same time, there are complementary safety strategies beyond compliance that could help save thousands of lives.

There are many unexploited opportunities for the motor carrier industry to markedly lower safety risk by improving safety management practices and implementing existing technologies. In our discussions with industry and other stakeholders, we found evidence that both of these approaches are already emerging. Many large motor carriers have, or are developing, sophisticated safety management systems. Safety devices like Electronic Logging Devices (ELD), Speed Limiters, and Driver Cameras are also being adopted voluntarily by motor carriers. In conversations with insurance and shipping companies, we found the marketplace is prepared to reward those operators for their “best practice” commitments and safety-technology investments. Segments of the industry are poised to achieve significant safety improvements. For that to happen, the community needs FMCSA to actively lead the way, with strategies that go beyond regulatory compliance.

FMCSA Formative Leadership and Guidance—FMCSA could provide, encourage, or facilitate:

- Implementation of new safety technologies;
- Safety management systems tailored to the size and complexity of the motor carrier;
- Programs to facilitate sharing and analysis of voluntarily-provided safety information;
- Development of safety data protection policies that allow carriers to identify safety problems without the threat of self-incrimination;
- Exchange of safety practices among peer motor carriers;
- Alternative compliance and enforcement policies that ensure appropriate oversight of advanced safety practices; and
- Audit standards allowing industry to take greater safety performance ownership.

The IRT is very familiar with examples of extraordinary safety gains generated through careful collaboration between airlines and the FAA. In 1997 the White House Commission on Aviation Safety and Security put in place an industry partnership known as the Commercial Aviation Safety Team. The team was tasked with reducing the fatal accident rate by 80 percent over 10 years. At that time, many in the aviation industry dismissed that goal as being unattainable and impossibly expensive. The FAA and industry ultimately exceeded that goal by delivering an 83 percent reduction from 1997 to 2007. Since then the fatal accident rate has continued to decrease. Major airline accidents are now so infrequent that it is difficult to even calculate the rate.

This decrease in accidents was not achieved through enforcement campaigns and massive increases in regulations. It was achieved largely through voluntary implementation of

safety and technology practices, targeted through the exchange of safety information, and fostered by complementary regulatory policies implemented by the FAA. In one example the FAA set up a pilot program to promote early voluntary adoption of rigorous safety management systems well in advance of rulemaking. Today 78 of 80 U.S. airlines are participating in the pilot program and are in complete compliance with the expected final rule. In another example, the FAA chose to encourage voluntary implementation of Flight Operations Quality Assurance (FOQA)³¹ programs (the equivalent of ELDs). The FAA never initiated official rulemaking because of concerns over the potential cost. Today more than 90 percent of operations are voluntarily covered by airline participation in FAA FOQA programs. Significantly, implementation of voluntary programs have not been limited to the large airlines—some of the most vocal advocates of the FAA’s voluntary safety programs are airlines with fewer than 10 aircraft.

The motor carrier community may be tempted to dismiss the comparison to aviation as irrelevant, but it can be argued that such an approach developed in concert with current enforcement efforts could yield even greater results than seen in aviation. First, in the motor carrier industry there are simply more accidents to prevent and more lives to be saved. Second, there is a broad array of technologies available with clear benefits, and these technologies do not face the extraordinary certification hurdles present in the aviation industry. Simply put, the motor carrier industry is in a much better position to innovate. Finally, the marketplace in the motor carrier industry is better equipped to recognize and reward safety performance. Consumers rarely make a decision based on the safety record of a major U.S. airline when buying a ticket, assuming all of them are equally safe. Airlines see little commercial competitive advantage from safety investments. In the motor carrier industry, however, shippers and insurance underwriters know there is a significant difference in safety practices between operators, and they are willing to discriminate between them on that basis. Depending where one sits, this behavior may be viewed as commendable or lamentable, but either way it is already elevating the business case for motor carrier safety.

FMCSA’s regulated industry is more diverse than the airline industry. Application of these types of cooperative safety structures should be carefully targeted to suitably motivated companies. FMCSA would apply different models to different parts of the industry, depending on the motor carriers’ levels of technical competence and compliance orientation. FMCSA would retain the ability to hold less motivated companies tightly accountable for compliance with prescriptive rules, alleviating any concerns that stakeholders might have with regard to the use of cooperative models with fundamentally irresponsible companies.

Small Business Participation—It is important that any program for voluntary safety initiatives offer small businesses an opportunity to take part. Since risk management and similar programs require management support and expertise not always readily available

³¹ FOQA is for the routine collection and analysis of digital flight data generated during aircraft operations. FOQA programs provide more information about, and greater insight into the total flight operations environment.

to small businesses, it is important to consider approaches to expand their opportunities to obtain such support. For example:

- Small motor carriers may be able to obtain this help through associations that could, develop and offer to their members' model plans, expert assistance, or certified inspectors.
- Small motor carriers may also be able to obtain this assistance by organizing consortiums with other small carriers or by turning to bigger carriers who could offer to include them under their plans or provide other assistance.

To ensure that opportunities to participate are effectively provided, FMCSA would have to consider such things as providing information on alternative approaches that are available and additional time to participate while the small carriers explore and develop their options. One model for this approach can be found in DOT's drug and alcohol testing rules, which cover the motor carrier industry and other modes of transportation.

Recommendation 3.1

FMCSA, the motor carrier industry, and other stakeholders should develop a mechanism that allows for the cooperative development and coordinated implementation of voluntary safety programs.

Recommendation 3.2

FMCSA should work closely with the motor carrier industry and other stakeholders to develop approaches that will enable small motor carriers to participate effectively in any voluntary safety program.

4.0 Implementation and Expectations

The IRT has provided a range of recommendations it believes will help FMCSA address its challenges. As the IRT has noted in this report, FMCSA recognizes the need for changes to its compliance program and is already altering its investigative techniques in a positive way. As we started developing our recommendations, we found the Agency was exploring some of the same solutions on its own initiative. As we looked at alternative approaches, we received positive feedback from FMCSA's senior leadership. They are supportive of many of these ideas, have raised many related and relevant questions, and have worked with us to develop new approaches to performance measurement and program evaluation.

At the same time, we are concerned that the Agency may already be attempting to make too many changes, too quickly. This results in part from a genuine desire to improve and in part from an accumulation of external pressures. The IRT hopes that this report will not become yet another source of pressure, but will clarify the fundamental nature of the issues to be resolved, and provide some pointers for constructive future development.

There is much that FMCSA needs to do. They want to do it. They need to be allowed the freedom and the time to do it.

The IRT understands FMCSA does not exist in a vacuum. A broad range of organizations will eventually have to consider whether FMCSA operations are effective and aligned with the mission. Concerned stakeholders include the Secretary of Transportation (for whom this report was written), Executive and Legislative Branch oversight organizations, NTSB, industry associations and operators, and advocates for victims of motor carrier crashes. Consensus regarding major changes may yet be far off. But lives are at stake every day, so we have tried to provide some immediate steps that ought not be controversial and which nevertheless represent important steps in a constructive direction.

In response to Secretary Foxx's direction, the IRT has identified high-impact items that are also directly relevant to NTSB concerns that FMCSA should target for immediate action:

- **Training:** FMCSA is already providing its workforce with training in Enhanced Investigative Techniques. It should measure the impact this training has on the patterns of violations that are cited (Section 2.1). It should also implement some level of quality assurance to make sure new positive investigator behaviors are reinforced (Section 2.6).
- **Policy:** As mentioned in the report, there are limits to what can be accomplished through training. FMCSA should pursue some early incremental policy changes that make it easier for investigators to cite violations better correlated to the risk of crashes (Section 2.1).
- **Risk Management:** There is an urgent need to deal with the untreated risk pool of potentially high-risk carriers that have been identified but not yet reviewed. The

vast majority of this lag-related risk exists in a handful of states. FMCSA could address this problem by more extensive sharing of federal staffing across divisions and by beginning to redistribute federal and state resources on a more permanent, need-driven basis (Section 2.2).

- **High Risk Carriers:** Action should be taken to identify the highest risk carriers in the compliance review backlog. FMCSA should consider the IRT's recommendations in Section 2.2, and if necessary, seek relief from current mandates to free up resources so they may act more quickly on the highest risk carriers.

The IRT believes all of the remaining issues cited in this report, while important, can be treated with a different level of urgency. FMCSA must be allowed the opportunity to address these issues as a part of a cohesive plan that reconciles changes already in process with those adopted from this report. A deliberate and deliberative approach will make the changes more orderly and the communications with employees and stakeholders more fruitful. As the Agency develops its plan, it is likely to discover more reasonable or feasible solutions to the underlying problems identified in this report. FMCSA creativity should be fostered as long as the issues are addressed effectively. Whatever plan is ultimately produced, FMCSA needs to demonstrate its suitability and effectiveness in resolving these specific issues.

The IRT has included some recommendations that are not entirely within the control of FMCSA to implement. For instance, in Section 2.3 the IRT addresses the controversial subject of SMS data. The IRT is as much concerned with the nature of the debate as it unfolds, as it is with the substantive arguments being made. If unchanged, the tenor of this debate could stall the implementation of FMCSA's safety program for a very long time. The IRT has suggested ways to change the conversation, but it will be up to industry, FMCSA, and other stakeholders together to commit to finding a constructive path forwards.

The IRT underlined an important need for FMCSA to move beyond regulatory compliance to a broad array of safety programs that could have an immediate and substantial impact. These include the possibility of adopting voluntary safety programs. Industry can work in partnership with FMCSA to assume greater responsibility for its safety practices. Such programs require a level of trust and maturity on behalf of the industry, as well as a different type of engagement by the regulator and different forms of participation from other stakeholders. If done well, such programs may have an extraordinary effect and save many lives. The IRT offers suggestions as to how FMCSA might initiate such collaborations. We very much hope that industry and other stakeholders will embrace such efforts to improve public safety.

Appendix 1: Glossary of Acronyms and Technical Terms

A

ATRI American Transportation Research Institute

B

BASICS Behavior Analysis Safety Improvement Categories

C

CMV Commercial Motor Vehicle

CR Compliance Review

CSA Compliance, Safety, Accountability Program

D

DIR Driver Information Resource

DOT Department of Transportation

E

eFOTM Electronic Field Operations Training Manual

EIT Enhanced Investigator Techniques

ELD Electronic Logging Devices

F

FAA Federal Aviation Administration

FPS Federal Program Specialist

FMCSA Federal Motor Carrier Safety Administration

FMCSR Federal Motor Carrier Safety Regulations

FOQA Flight Operations Quality Assurance

G

GAO Government Accountability Office

H

HOS Hours of Service

I

IRT Independent Review Team

IG Department of Transportation Inspector General

ISS Inspection Selection System

M

MCSAP Motor Carrier Safety Assistance Program

N

NAS New Applicant Screening
NTSB National Transportation Safety Board
NOC Notice of Claim
NOV Notice of Violation

P

PSP Pre-Employment Screening Program

S

SMS Safety Measurement System
SFD Safety Fitness Determination
SSDQ State Safety Data Quality

U

UMTRI University of Michigan Transportation Research Institute
URS Unified Registration System

Appendix 2: Biographical sketches of the IRT members

William Voss is the Deputy Director of the FAA's Air Traffic Oversight Service. He is a member of the executive team responsible for the regulation and safety oversight of the U.S. air traffic control system. Previously, he was on special assignment to the Federal Transit Administration to assist in the establishment of a new MAP-21 safety oversight system. He was also CEO of Flight Safety Foundation and recognized as an international expert on safety management systems and safety oversight. Mr. Voss served as an advisor to multiple aviation regulatory authorities and was a senior official at the International Civil Aviation Organization responsible for the development of international aviation safety standards and for the implementation of these standards into 189 international aviation regulatory systems.

Jacqueline Duley, PhD is the Director of TASC Inc.'s Transportation Division. Her division supports DOT and DHS to achieve efficient, safe, and secure transport of goods and people. Her staff provides systems engineering, T&E, program/acquisition support, and specialized engineering and analytics. She personally has extensive experience in safety management systems, system safety, human factors engineering, human factors requirement development and analysis, user interface design, and operational system evaluations in the aviation and surface transportation industries.

Neil Eisner served as US DOT Assistant General Counsel for Regulation and Enforcement from 1978-2013. He also served as FAA Deputy Assistant Chief Counsel for Litigation and Acting Assistant Chief Counsel for Regulations and Enforcement. Mr. Eisner is an expert on a variety of administrative law matters, including regulatory compliance issues.

Lynne Judd was Wisconsin's Motor Vehicle administrator from 2005 to 2013 and managed highway program field operations for the Wisconsin DOT from 2001-2005. She was the 2010-11 chair of the board of the American Association of Motor Vehicle Administrators (AAMVA) and served on that board for six years. Ms. Judd was also an active member of the Standing Committee on Highway Traffic Safety for the American Association of State Highway and Transportation Officials (AASHTO) for several years.

William McCabe is the founder of the McCabe Group, a leadership and safety culture consultancy. He was a member of the Blue Ribbon Panel appointed by Secretary of Transportation Mary Peters to review the FAA's approach to safety. He was also selected by the Washington Metropolitan Area Transit Authority (WMATA) Board of Directors to provide operational safety leadership, analysis, and guidance for WMATA's senior management and rail and bus workforce.

Charles Raley is an attorney with the FAA's Office of the Chief Counsel, Enforcement Division. He was a US Naval Aviator from 1994-2005 and has extensive experience in aviation and ground safety programs.

Appendix 3: IRT Interactions

- **Advocacy**
 - Road Safe America
 - Truck Safety Coalition
- **DOT IG**
- **FMCSA**
 - Approximately 85 current or former FMCSA employees
- **GAO**
- **Insurance/Broker Industry**
 - Central Analysis Bureau
- **Motor Carrier Industry Groups**
 - Air and Expedited Motor Carrier Association
 - Airforwarders Association
 - American Trucking Association
 - Commercial Vehicle Safety Alliance
 - NAFA Fleet Management Association
 - National Association of Small Trucking Companies
 - Owner Operator Independent Drivers Association
 - Transportation Intermediaries Association
 - United Motorcoach Association
- **Motor Carriers**
 - Approximately 50 personnel from various motor carriers
- **NTSB**
- **States**
 - Approximately 25 personnel from state partners
- **Unions**
 - Amalgamated Transit Union
 - International Brotherhood of Teamsters, Freight Division
- **Other Stakeholders**
 - American Bakers Association
 - American Pyrotechnics Association
 - Institute of Makers of Explosives
 - McBee Strategic
 - NATC
 - National Association of Trailer Manufacturers
 - National Propane Gas Association
 - National RV Dealers Association
 - National Shippers Strategic Transportation Council
 - North American Transportation Consultants, Inc.
 - Snack Food Association
 - US Chamber of Commerce

Appendix 4: Safety Fitness Requirements

FMCSA established a procedure³² to determine the safety fitness of motor carriers through the assignment of safety ratings and established a “safety fitness standard” that a motor carrier must meet to obtain a *satisfactory* safety rating.

The safety rating process developed by FMCSA is used to:

1. Evaluate safety fitness and assign one of three safety ratings (*satisfactory*, *conditional*, or *unsatisfactory*) to motor carriers operating in interstate commerce in accordance with §§ 385.5, Safety fitness standard, and 385.7, Factors to be considered in determining a safety rating.
2. Identify motor carriers needing improvement in their compliance with the Federal Motor Carrier Safety Regulations (FMCSRs) and applicable Hazardous Materials Regulations (HMRs). These are carriers rated *unsatisfactory* or *conditional*.

FMCSA's rating process is built on the operational tool known as the Compliance Review (CR). FMCSA developed this tool to assist Federal and State safety specialists in gathering pertinent motor carrier compliance and accident information. The CR is an in-depth examination of a motor carrier's operations and is used:

1. to rate unrated motor carriers,
2. to conduct a follow-up investigation on motor carriers rated *unsatisfactory* or *conditional* as a result of a previous review,
3. to investigate complaints, or
4. in response to a request by a motor carrier to reevaluate its safety rating.

Investigators examine documents such as those contained in driver qualification files, records of duty status, vehicle maintenance records, and other records for compliance with the regulations. Investigators use performance-based information, when available, to evaluate the carrier's compliance with the vehicle regulations. They also collect accident information.

FMCSA gathers information through an examination of the motor carrier's compliance with identified “acute” or “critical” regulations. Acute regulations are those identified where noncompliance is so severe as to require immediate corrective actions by a motor carrier regardless of the overall safety posture of the motor carrier. Critical regulations are those identified where noncompliance relates to management and/or operational controls. These are indicative of breakdowns in a carrier's management controls. The list of acute and critical regulations that are used in determining safety ratings is included 49 CFR Part 385, Appendix B.

³² See 49 CFR Part 385.

Parts of the regulations having similar characteristics are combined together into six regulatory areas called “factors.” The regulatory factors, evaluated on the adequacy of the carrier's safety management controls, are:

- Factor 1 General=Parts 387 and 390
- Factor 2 Driver=Parts 382, 383 and 391
- Factor 3 Operational=Parts 392 and 395
- Factor 4 Vehicle=Parts 393 and 396
- Factor 5 Hazardous Materials=Parts 397, 171, 177 and 180

In addition to the five regulatory factors, a sixth factor, Accidents, is included in the process to address the accident history of the motor carrier. The recordable accident rate is used to determine the carrier's basic safety management controls in Factor 6, Accident. It is used only when a carrier incurs two or more recordable accidents within the 12 months before the safety audit.

For Factors 1-5, if the combined violations of acute and/or critical regulations for each factor is equal to three or more points, the carrier is determined not to have basic safety management controls for that individual factor. For Factor 6, if the recordable accident rate is greater than 1.7 recordable accidents per million miles for an urban carrier (1.5 for all other carriers), the carrier is determined to have inadequate basic safety management controls.

For each instance of noncompliance with an acute regulation, FMCSA assesses 1.5 points. For each instance of noncompliance with a critical regulation, FMCSA assesses 1 point. The factor ratings are as follows:

- “Satisfactory”—if the acute and/or critical=0 points
- “Conditional”—if the acute and/or critical=1 point
- “Unsatisfactory”—if the acute and/or critical=2 or more points

FMCSA enters the ratings for the six factors into a rating table that establishes the motor carrier's safety rating.

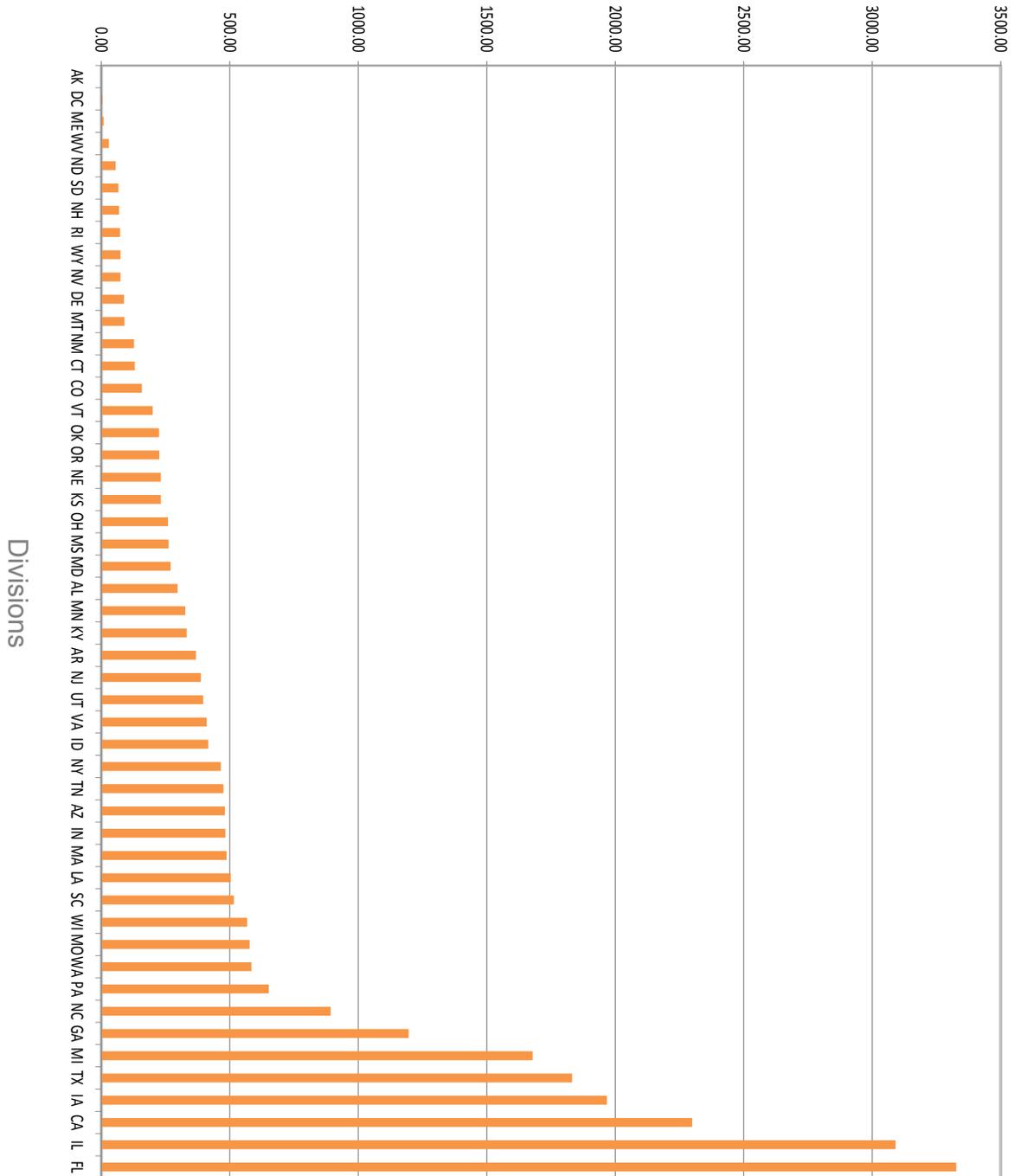
Factor ratings		Overall Safety rating
Unsatisfactory	Conditional	
0	2 or fewer	Satisfactory
0	more than 2	Conditional
1	2 or fewer	Conditional
1	more than 2	Unsatisfactory
2 or more	0 or more	Unsatisfactory

Appendix 5: FMCSA Analysis of Focused CRs

Compare BASICS in Alert at time of prioritization vs Serious Violations found in Reviews	Any BASIC	Unsafe Driving	HOS	Driver Fitness	Drugs/Alcohol	Vehicle Maintenance	Hazardous Materials	Crash Indicator
Focused CR where carrier had BASIC in alert status at time of prioritization	6,732	2,022	4,101	521	127	2,688	76	987
Focused CR where carrier had BASIC in alert status at time of prioritization and had a Serious Violation in same BASIC in the review	1,482	4	934	148	18	512	6	-
	22.01%	.20%	22.77%	28.41%	14.17%	19.05%	7.89%	

Appendix 6: Carrier Months of Mandatory Status

No. of Reviews x Avg No. Months to Complete



CY2013 Reviews on Mandatory Carriers and Average Completion Time

OIC State (FMCSA Division)	Number of Reviews on Mandatory Carriers	Avg Number of Months between Prioritization and Review	Number of Reviews on Mandatory Carriers where review was done more than 12 months after prioritization	Carrier Months of Mandatory status
AK	1	1.097	0	1.10
DC	2	2.355	0	4.71
ME	5	1.948	0	9.74
WV	16	1.859	0	29.74
ND	11	5.091	1	56.00
SD	16	4.177	0	66.84
NH	15	4.622	0	69.32
RI	10	7.303	1	73.03
WY	10	7.432	1	74.32
NV	22	3.397	0	74.74
DE	13	6.777	1	88.10
MT	15	6.006	1	90.10
NM	27	4.724	0	127.55
CT	35	3.722	3	130.26
CO	41	3.848	1	157.77
VT	21	9.521	0	199.94
OK	71	3.165	0	224.74
OR	34	6.632	2	225.48
NE	64	3.613	1	231.23
KS	59	3.922	1	231.39
OH	74	3.507	2	259.48
MS	61	4.290	5	261.68
MD	79	3.410	4	269.35
AL	92	3.227	3	296.84
MN	88	3.715	3	326.94
KY	70	4.743	0	332.00
AR	54	6.826	0	368.58
NJ	93	4.166	0	387.45
UT	59	6.718	4	396.39
VA	108	3.796	4	410.00
ID	54	7.707	4	416.19
NY	107	4.347	2	465.16
TN	76	6.253	11	475.26

OIC State (FMCSA Division)	Number of Reviews on Mandatory Carriers	Avg Number of Months between Prioritization and Review	Number of Reviews on Mandatory Carriers where review was done more than 12 months after prioritization	Carrier Months of Mandatory status
AZ	76	6.329	9	481.00
IN	109	4.429	1	482.81
MA	72	6.767	8	487.23
LA	71	7.090	9	503.35
SC	98	5.266	3	516.03
WI	112	5.066	2	567.42
MO	103	5.601	4	576.87
WA	94	6.211	10	583.84
PA	71	9.177	20	651.55
NC	136	6.561	18	892.26
GA	272	4.397	6	1196.06
MI	181	9.273	33	1678.42
TX	519	3.530	9	1832.06
IA	170	11.573	88	1967.35
CA	325	7.075	58	2299.52
IL	392	7.885	59	3090.81
FL	323	10.301	93	3327.19
TOTAL	4627	6.044	485	

Appendix 7: FMCSA Response to High Profile Crashes

FMCSA leadership recognized a need to re-think its approach to enforcement, particularly for passenger carriers, well before NTSB sent its recommendations to the USDOT Secretary in November 2013.³³ Over the prior two years, FMCSA managers had been working to expand and improve the enforcement tools available to investigators.

In January of 2013, Administrator Ferro challenged her managers to re-invent the agency's paradigm for motor coach safety. The result was rapid development and implementation of Enhanced Investigator Training (EIT) and the Quick Strike enforcement approach. The agency effected these changes with remarkable speed, as shown in the timeline below:

2013

- January: strategy team convened
- February: team's recommendations for specialized training and expanded use of enforcement tools adopted; implementation team convened; new training designed
- March: course content determined, scope of first quick strike investigations determined, first EIT course held by the close of the month
- April: quick strike investigations initiated, progress and results monitored via management review of available data and conference calls, agency-wide communication undertaken
- May through August: quick strike investigations and monitoring continued
- September: second EIT training course held
- October: quick strike investigations completed, results show increased enforcement effectiveness, decision to expand EIT training to all investigators and their supervisors, instructors identified
- November through December: preparation for expanded training

2014

- January: third EIT training course held, field leadership recommends changing the performance metric to recognize quality of investigations, rather than only number of investigations, work on new performance standards initiated.
- March: fourth EIT training course held
- May through November: courses are continuing, agency expects to complete training of all federal personnel by November; team named in May/will meet in July to plan roll out of EIT to state partners

³³ Summary prepared by IRT based on input from FMCSA staff.

FMCSA management also provided the IRT with reviews produced by the applicable divisions after the four crashes that formed the basis of the NTSB recommendations. These demonstrate management recognition of the need to review agency actions where enforcement efforts have touched, but not taken out of service, a carrier that is then involved in a very serious crash. The content, format, and degree to which changes that might avoid such occurrences in the future are identified vary greatly between the reports. However, the following issues and opportunities were recognized:

- Need for management oversight is greater with newer/developing investigators.
- Seasonal variations (e.g., tour operators) may affect the evidence available at the time of an investigation.
- Translation services are necessary, but have not always been available, for review and interpretation of carrier records kept in a foreign language; FMCSA seems to have made some progress on this issue.
- State and local safety partners and other federal agencies can sometimes provide additional information about a carrier and assistance in assessing the carriers' safety compliance.
- Expanded discretion on the part of the investigator is needed in order to improve the likelihood that crash-predicting violations will be discovered and acted on before a crash occurs.

FMCSA management determined that the pre-crash investigations had followed policy then in effect and that policy changes and enhanced training were needed in order to improve the effectiveness of CRs. These changes—including expanded investigator discretion, relief from purely numeric performance standards, and training to improve investigative techniques and mindset—are in the process of being implemented.

The IRT has seen evidence, discussed in the body of this report, that staff are not all equally well-informed about recent agency initiatives and that the disconnect between priority-setting based on roadside data and fitness determinations based on section 385 that results from the partial implementation of CSA is impeding the program's effectiveness. The IRT has also seen that mandates and pressures from outside the agency drain resources that might be devoted to more orderly implementation. It is clear, however, in the urgency given to improving enforcement effectiveness in the face of evidence that it could be better, that FMCSA staff and leadership are fully committed to the agency's safety mission

The crashes cited in NTSB's letter to Secretary Foxx:

MOTOR COACH: Mi Joo Tour & Travel – December 30, 2012
 Scapadas Magicas LLC – February 3, 2013

PROPERTY CARRIER: Highway Star, Inc. – March 2, 2013
 H & O Transport – June 13, 2013

Appendix 8: FMCSA Passenger Task Force Analysis Phase I

	Passenger Group	Task Force 2012	Task Force 2013
Average Number of Serious Violation Per Investigation	0.81	0.80	4.20
Average Acute Violations	0.06	0.07	0.66
Average Critical Violations	0.49	0.54	3.03
Average "Other" Serious Violations	0.78	0.75	3.72
Average Number of Non-Serious Violations Per Investigation	8.17	7.04	14.05
Percent of Investigations with Serious Violations	33.2%	32.2%	71.6%

Appendix 9: NTSB Letter and DOT Secretary Letter Response



National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: November 5, 2013

In reply refer to: H-13-039 and -040

The Honorable Anthony R. Foxx
Secretary
US Department of Transportation
Washington, DC 20590

The National Transportation Safety Board (NTSB) investigated four recent commercial motor vehicle crashes that, together, resulted in 25 deaths and injuries to 83 people. The crashes all raised safety issues about the oversight of US motorcoach and trucking industry operations by the Federal Motor Carrier Safety Administration (FMCSA). Additional information about these specific crashes can be accessed through our website, www.nts.gov, under the following report numbers: HWY-13-FH-005 (Pendleton, Oregon), HWY-13-FH-007 (San Bernardino, California), HWY-13-FH-008 (Elizabethtown, Kentucky), and HWY-13-FH-015 (Murfreesboro, Tennessee).¹

The NTSB investigations of the four crashes described in this letter—two involving motorcoaches and two involving commercial property operations—all prompt concern about FMCSA oversight practices with respect to the motor carriers operating the commercial vehicles. The Pendleton, Oregon, motorcoach crash might have been prevented if FMCSA oversight of the motor carrier during the compliance review (CR) process had identified the safety problems that were subsequently enumerated in a postcrash imminent hazard order. The NTSB investigation of the second motorcoach crash, in San Bernardino, California, found that the FMCSA had conducted CRs on the motor carrier without making a complete review of its business records. In addition, despite the FMCSA's having documented numerous vehicle violations associated with the carrier in roadside inspections, the most recent precrash CR of the carrier did not include inspection of any vehicles. After providing a description of these two motorcoach crashes and the NTSB investigation of the motor carriers involved, this letter discusses the NTSB concerns regarding the quality of CR investigative work.

The third and fourth crashes involved commercial property operations. NTSB investigation of the crash in Elizabethtown, Kentucky, revealed that the FMCSA's investigative work and its on-site focused CR of the commercial property operator, conducted days before the crash occurred, did not uncover the carrier's violations of the Compliance, Safety,

¹ The reports may be found in the NTSB public docket for these investigations, which is accessible via the website.

Accountability (CSA) program's Behavior Analysis and Safety Improvement Categories (BASICS) in the hours-of-service (HOS) compliance area, despite a history of violations, because the focused review was conducted only on the Unsafe Driving BASIC.² In addition, the NTSB investigation of an operator involved in a fatal crash near Murfreesboro, Tennessee, uncovered carrier violations in the HOS compliance area that were not identified in a June 2011 Non-Rated on-site focused CR. The focused CR was prompted by an alert in the Unsafe Driving BASIC, but the carrier had a history of alerts in the HOS BASIC.³ Following a discussion of these two commercial property operation crashes, this letter explains the NTSB's concern with the limited scope of the focused CRs conducted by the FMCSA. In these cases, focused CRs that considered only the Unsafe Driving BASIC resulted in the failure to detect safety violations by the motor carriers that later contributed to fatal crashes.

Two Motorcoach Crashes and the CRs Conducted on the Carriers Involved

Mi Joo Tour & Travel Crash in Pendleton, Oregon

On Sunday, December 30, 2012, about 10:30 a.m. Pacific standard time (PST), a 1998 Prevost motorcoach, operated by the Canadian motor carrier Mi Joo Tour & Travel, was traveling westbound on Interstate 84, near Pendleton, Oregon. The motorcoach was on a trip from Las Vegas, Nevada, to Vancouver, British Columbia; on the day of the crash, it had departed from Boise, Idaho. Snow and ice had accumulated along the route, which traverses a rural area of the Blue Mountains. The motorcoach, upon encountering ice, slid off the roadway, struck a W-beam roadside barrier, went down an embankment, overturned, and came to rest upright at the bottom of the slope. As a result of the crash, 9 of the vehicle's 47 occupants died. The driver and an additional 37 passengers were injured.⁴

Postcrash investigation by NTSB investigators and the Oregon State Police determined that the motorcoach had been traveling too fast for the weather and roadway conditions. In addition, the driver was unsafely operating the motorcoach with the transmission retarder engaged,⁵ and the motorcoach was equipped with a tire not properly speed-rated for highway operations.⁶ The NTSB review of Mi Joo Tour & Travel and its driver determined that the driver was operating in violation of the 70-hour rule under federal HOS regulations for passenger-carrying commercial motor vehicles at the time of the crash. The NTSB did not determine a probable cause for this crash; however, based on the driver's HOS violation, fatigue may have contributed to his operational errors of traveling too fast for the road conditions and of

² The BASIC categories are as follows: Unsafe Driving, HOS, Driver Fitness, Controlled Substances/Alcohol, Vehicle Maintenance, Hazardous Materials, and Crash Indicator.

³ A review of the carrier's history in the Safety Measurement System (SMS) indicated that it had alerts in the HOS BASIC from November 19 to December 17, 2010; from June 24 to August 26, 2011; from October 28 to December 16, 2011; and from April 27, 2012, to May 24, 2013.

⁴ See HWY-13-FH-005 for more information.

⁵ The motorcoach was equipped with an Allison automatic transmission retarder to help slow the vehicle, thereby reducing the need to use the wheel brakes. Guidance from the *Commercial Driver's License Manual* cautions that "When your drive wheels have poor traction, the retarder may cause them to skid. Therefore, you should turn the retarder off whenever the road is wet, icy, or snow covered." (American Association of Motor Vehicle Administrators, *Commercial Driver's License Manual*, 2006, p. 2-10.)

⁶ A postcrash inspection of the motorcoach showed that the vehicle was equipped with one tire that was speed-rated for 55 mph.

leaving the transmission retarder engaged.⁷ Mi Joo Tour & Travel had previously been cited twice for Part 395 HOS violations: one of those violations resulted in an out-of-service (OOS) order.

Mi Joo Tour & Travel had passed the US New Entrant Program safety audit in July 2007 and completed the program on August 20, 2008, at which time the Canadian company received permanent authority to operate in the United States. The FMCSA subsequently conducted CRs on Mi Joo Tour & Travel on July 13, 2010, and August 24, 2011. The 2010 CR resulted in a Conditional rating; the 2011 CR resulted in a Satisfactory rating. On the basis of the 2011 CR, the FMCSA issued Mi Joo Tour & Travel a Notice of Claim (NOC) fine of \$2,000 for a driver violation.⁸ The company did not pay the NOC fine and on January 9, 2012, the FMCSA issued it an OOS order. Mi Joo Tour & Travel then paid the fine, and the FMCSA rescinded the OOS order on March 27, 2012. Nine months later, the Pendleton, Oregon, crash occurred.

The NTSB postcrash review of the motor carrier determined that Mi Joo Tour & Travel had no safety plan and no written policies or procedures—including no hiring procedures, no preventative maintenance program for its vehicles, no safety management review procedures for monitoring driver hours of service, and no in-service training for its drivers. Following the crash and the NTSB's investigation of the motor carrier, the FMCSA conducted a CR on Mi Joo Tour & Travel, which was completed on January 17, 2013. As a result of the evidence obtained during the postcrash CR, the FMCSA put the company, the crash driver, and a second motorcoach driver on the trip out of service and determined that Mi Joo Tour & Travel was an imminent hazard to public safety. The FMCSA imminent hazard operations OOS order stated (in part) that the basis of the order was as follows:

MI JOO TOUR & TRAVEL wholly fails to take basic measures to ensure that its drivers are properly rested for safe vehicle operations. MI JOO TOUR & TRAVEL fails to monitor and ensure that its drivers comply with drivers' hours of service requirements, drivers' records of duty status (RODS) requirements, and recordkeeping retention requirements, thereby posing a continuing imminent hazard....⁹

Based on the CR records, the problems identified with Mi Joo Tour & Travel were longstanding and systemic, dating to when the company first began operations and passed the New Entrant Program safety audit in July 2007. The fact that Mi Joo Tour & Travel received a Satisfactory rating during its August 24, 2011, CR raises serious concerns regarding the thoroughness of the FMCSA CR process. This 2011 CR noted only two violations of 49 CFR Part 396—in the vehicle maintenance and inspection categories—and neither of those violations were classified as "critical" or "acute"; consequently, the violations did not count toward the carrier's rating. However, the postcrash CR noted the following deficiencies with respect to the carrier's operation:

⁷ Title 49 *Code of Federal Regulations* (CFR) 395.5(b)(2) prohibits driving after 70 hours of on-duty time in a consecutive 8-day period if the employing motor carrier operates passenger-carrying commercial motor vehicles every day of the week.

⁸ The 2011 CR was prompted because the carrier had alerts for the Driver Fitness and Controlled Substances/Alcohol BASICs. The carrier also had a postcrash HOS alert (score of 76.9 percent, above the category threshold of 50 percent).

⁹ See Imminent Hazard Operations Out-of-Service Order WA-2013-5000-IMH, issued January 8, 2013.

- Continued noncompliance with drug and alcohol testing requirements,
- No postcrash controlled substance testing,
- Failure to maintain driver qualification requirements,
- Failure to comply with the HOS regulations,
- Failure to properly maintain commercial motor vehicles,
- Failure to require drivers to properly prepare driver inspection reports,
- Continued operation while under an OOS order.

Some of the issues involved in the Pendleton crash, such as unsafe speed, improper use of a transmission retarder under slippery roadway conditions, vehicle equipment deficiencies, and possible driver fatigue connected to driving in violation of HOS regulations, can be directly attributed to poor safety management on the part of Mi Joo Tour & Travel. This fatal crash might have been prevented if the FMCSA had exercised more effective federal oversight of the carrier during the CR process. The FMCSA should have identified the safety problems enumerated in the postcrash imminent hazard order before the crash occurred, during the CRs conducted in July 2010 and August 2011, and required corrective action or put Mi Joo Tour & Travel out of business before the crash took place in 2012.

Scapadas Magicas LLC Crash in San Bernardino, California

Five weeks after the Pendleton, Oregon, motorcoach crash, the NTSB investigated a second multiple-fatality motorcoach crash, which took place near San Bernardino, California. On Sunday, February 3, 2013, about 6:29 p.m. PST, a 1996 Van Hool motorcoach was traveling westbound on State Route 38 (SR-38), a two-lane highway with one lane traveling westbound (downhill) and one lane traveling eastbound (uphill), near the end of a mountainous portion of the route. The motorcoach was returning to Tijuana, Mexico, from Big Bear Lake, California. The motorcoach was owned and operated by Scapadas Magicas LLC and was occupied by 40 passengers and a 52-year-old male driver. As the motorcoach continued downhill, the driver had difficulty slowing and lost control of the vehicle. The motorcoach collided with the rear and left side of a 2007 Saturn Aura, occupied by a driver and two passengers, which was ahead of the motorcoach in the same lane. The Saturn was deflected out of the path of the motorcoach. After exiting a left curve, the motorcoach crossed into the opposing (uphill) lane, struck an embankment on the left side of the roadway, and overturned toward the passenger side. The overturned motorcoach collided with a 1985 Ford F-150 Explorer pickup truck that was traveling eastbound (uphill), towing an enclosed utility trailer. The Ford was occupied only by the driver. During the collision sequence, several passengers were ejected from the motorcoach. The motorcoach and the Ford were redirected to the westbound lanes, where the bus rolled upright, struck a boulder adjacent to a drainage ditch on the right side of the roadway, and came to rest blocking both lanes of SR-38. As a result of the crash, 7 motorcoach passengers were fatally injured, the motorcoach driver and 11 passengers were seriously injured, and 22 passengers received minor injuries. The Saturn driver and its two passengers received minor injuries. The Ford driver died as a result of the crash.¹⁰

¹⁰ See HWY-13-FH-007 for more information.

Postcrash investigation by NTSB investigators and the California Highway Patrol identified numerous mechanical problems with the Van Hool motorcoach that directly contributed to the crash. Vehicle mechanical deficiencies were identified for all six brakes that would have qualified the brakes as defective according to the North American Standard Inspection Program OOS criteria. The lack of braking capability led to the driver's loss of vehicle control as the motorcoach traveled downhill.

The carrier had begun operating taxi and van service from Mexico to California as a sole proprietor in 1984 under the name "Ramon Ramirez." By 1996, it was doing business as a for-hire passenger carrier conducting interstate charter service under the name "Scapadas Magicas." The carrier received four CRs prior to 2011. The CR rating results were as follows: 2001, Satisfactory; 2007, Conditional; 2008, Satisfactory; and 2009, Satisfactory. In 2011, the company changed its business status from sole proprietorship to limited liability corporation (LLC). This status change prompted it to be identified by the FMCSA as a new entrant. The carrier exited the New Entrant Program with a Satisfactory CR rating in April 2011, and it received permanent operating status from the FMCSA on October 3, 2012.

During 2011 and 2012, Scapadas Magicas LLC received 19 roadside inspections, 6 of which resulted in one or more OOS violations, giving it a 42.8 percent vehicle OOS rate, about six times the annual national average for this factor, which is generally about 5–7 percent for same-class operations. Moreover, the motorcoach that crashed had received five roadside inspections in the previous 24 months; three of those five inspections identified brake OOS violations. Because of its history of problems with vehicle maintenance found during roadside inspections, Scapadas Magicas LLC received an alert in the Vehicle Maintenance BASIC; its score of 74 percent in this BASIC placed it in the worst 26 percent of all motor carriers for vehicle maintenance.

The NTSB's postcrash review of Scapadas Magicas LLC identified a serious lack of safety management controls on the part of the motor carrier. The company had no written safety policies for its drivers and no systematic preventative maintenance program for its vehicles. The carrier did not have a method or system of records for indicating when vehicles were due for service and lacked a systematic method of conducting repairs and servicing, as required under 49 CFR 396.3. The company owner stated that the mechanic who repaired the buses was not a Scapadas Magicas LLC employee. The carrier's operations manager, who was not a licensed mechanic, signed off on the orders for completed maintenance work.

In reviewing the FMCSA's oversight of Scapadas Magicas LLC prior to the crash, the NTSB identified a number of significant deficiencies in the CR process. On January 9, 2013, less than a month before the fatal crash, the FMCSA completed a full CR of Scapadas Magicas LLC and rated the company Satisfactory. The FMCSA conducted this CR because the carrier exceeded the BASIC threshold for roadside safety inspection violations associated with vehicle maintenance.¹¹ Despite the carrier's having an alert in the Vehicle Maintenance BASIC and a vehicle OOS rate of over 40 percent, the FMCSA conducted the 2013 CR of Scapadas Magicas LLC off site, at a self-storage facility, and no company vehicles were inspected. During

¹¹ A vehicle maintenance alert results when the score for that BASIC category exceeds the threshold value. The Vehicle Maintenance BASIC score for Scapadas Magicas LLC was 74 percent, well above the category threshold of 50 percent.

the review, the carrier informed the FMCSA safety investigator that its records were maintained at its principal place of business in Tijuana, Mexico. Those carrier maintenance receipts and repair orders that the carrier provided were written in Spanish. The report of the CR closeout review stated that "the carrier was not able to provide all requested documentation."

Less than a month after the FMCSA completed the January 2013 CR, which resulted in a Satisfactory rating for Scapadas Magicas LLC, the fatal San Bernardino crash took place, which occurred because of the poor condition of the motorcoach's brakes. Following the crash, the FMCSA issued an imminent hazard OOS order on February 8, 2013, to stop Scapadas Magicas LLC operations. The order stated that the company "fails to ensure that its commercial operations are systematically inspected, repaired and maintained and fails to ensure that its drivers are properly qualified and have appropriate licenses for the commercial motor vehicles they operate" and that the company "fails to ensure its commercial motor vehicles are properly and regularly inspected, repaired and maintained and fails to ensure that its drivers are knowledgeable in pre-inspection procedures and requirements."¹² The FMCSA postcrash investigation included safety inspections of two other motorcoaches operated by Scapadas Magicas LLC in the United States. The FMCSA found serious violations with both vehicles and placed them out of service.

Another issue that raises concern is the fact that the motorcoach that crashed had been issued a Commercial Vehicle Safety Alliance (CVSA) decal by an FMCSA safety investigator on October 25, 2012.¹³ Vehicles bearing a CVSA decal typically will not be stopped or reinspected during the 3-month time frame in which the decal is valid. The San Bernardino crash occurred 2 days after the decal expired. The NTSB believes that the mechanical conditions that were identified postcrash were longstanding problems and questions whether the vehicle should have received the CVSA decal. Improper vehicle maintenance was a leading investigative issue in this fatal crash, which might have been prevented had the FMCSA exercised effective motor carrier safety controls and adequate oversight of the carrier.

¹² See Imminent Hazard Operations Out-of-Service Order CA-2013-5000-IMHA, issued February 8, 2013.

¹³ To qualify for a CVSA decal, the vehicle must be inspected by an inspector certified to inspect to North American Standard Level I and/or Level V. The decal indicates that the vehicle did not have any violations of the items contained in the operational policy and North American Standard OOS criteria. CVSA decals, when affixed, remain valid for a period not to exceed 3 consecutive months.

Oversight Issues Common to Mi Joo Tour & Travel and Scapadas Magicas LLC

The two carriers involved in the motorcoach crashes discussed above and the deficiencies in the FMCSA's oversight of their operations share disturbing similarities. Mi Joo Tour & Travel began business as a travel agency in Canada. Scapadas Magicas LLC was originally a sole proprietor taxi service in Mexico;¹⁴ thus, both carriers were based outside of the United States and received US operating authority from the FMCSA. Neither company had a safety management plan, a preventative maintenance program, or a driver training handbook. Neither company owned a garage to maintain its fleet nor had a mechanic on staff. They did not have in-service driver training, their driver training files were incomplete, and their driver drug and alcohol programs were noncompliant. Yet both companies received Satisfactory ratings in the CRs the FMCSA conducted prior to their fatal crashes.

The FMCSA's operational monitoring systems—SafeStat and, more recently, the SMS¹⁵—identified potential safety problems with both of these carriers, specifically in the safety improvement categories related to their fatal crashes (Unsafe Driving and Vehicle Maintenance BASICS). Using the SMS to identify “at-risk” carriers, the FMCSA conducts CRs as the primary investigative and intervention method to determine the safety fitness of commercial operations and to compel operators to comply with the regulations. These monitoring systems triggered the CRs conducted for both carriers because each was indicated as possibly having safety deficiencies. However, the CR conducted on Mi Joo Tour & Travel 17 months prior to its fatal crash and the CR conducted on Scapadas Magicas LLC less than 1 month prior to its fatal crash both resulted in Satisfactory ratings. Then, immediately following each crash, the FMCSA issued an imminent hazard OOS order to stop operations, in recognition that the carriers were unsafe—despite having rated them Satisfactory in their most recent CRs. Also following each crash, NTSB investigators identified a lack of business documentation by the carriers and found that the FMCSA had conducted the most recent precrash CRs without carrying out a complete review of the companies' business records.

Questions Concerning FMCSA CR Quality Control Arising from the Pendleton and San Bernardino Investigations

The two motorcoach investigations described in this letter demonstrate clear problems in the execution of CRs. The NTSB is concerned that the CRs conducted on the carriers involved in these two crashes—Mi Joo Tour & Travel and Scapadas Magicas LLC—did not identify safety problems present at those firms. The carriers were correctly selected for safety review based on elevated SMS risk metrics identifying their safety deficiencies (thresholds exceeded in Unsafe Driving BASIC); however, the CR investigative work did not reflect violations in those BASICS. From the NTSB's vantage point, it is difficult to identify where the FMCSA failed in CR

¹⁴ Scapadas Magicas LLC incorporated in California in 2011. The April 8, 2013, postcrash CR recorded the carrier's physical business address as being in Tijuana, Mexico. Data from the carrier on FMCSA form MCS-150 showed a San Diego, California, mailing address and cited a principal place of business in National City, California. NTSB inspection of the National City business location indicated that the site was a self-storage unit facility. The FMCSA conducted the most recent CR at a carrier official's personal residence in California. Although the business's principal place of operation had a California address, investigators determined that the carrier's vehicles returned to Mexico each night, were driven by drivers who resided in Mexico, and received mechanical repairs and service in Mexico. Legally, its place of operation was California, but for all practical purposes, the carrier operated out of Mexico.

¹⁵ The SMS program replaced the SafeStat system in December 2010.

execution, but these cases illustrate that discrepancies exist between unsafe carrier operations and the FMCSA's evaluation of those operations. The FMCSA's own postcrash imminent hazard determinations for both carriers confirm that the precrash CRs conducted on them—which had Satisfactory results—were deficient.

As a practical matter, the quality of investigative work is a line management responsibility. The work of conducting CRs is organized under the FMCSA regional service centers:¹⁶ both Mi Joo Tour & Travel and Scapadas Magicas LLC were under the jurisdiction of the FMCSA Western Service Center. An FMCSA field investigator's work is reviewed by federal program managers, and enforcement specialists manage the associated penalties and court cases. The FMCSA periodically reviews selected investigative work. This management structure, which provides for internal oversight and case review, should have identified incomplete CR case work; however, the fact that it did not in these two cases leads the NTSB to conclude that the agency needs more effective processes to assess the quality of its own CR investigative work.

As the FMCSA seeks to increase operational efficiencies and address compliance and safety deficiencies across a broader segment of the motor carrier industry, the quality of its investigative oversight becomes more vital than ever. FMCSA management must ensure the quality of its investigators' work products, specifically for at-risk carriers, which are identified on the basis of a high value (exceeding the threshold) in one or more BASICs or because of their history of past enforcement actions. The FMCSA has repeatedly testified before Congress that CRs are time-intensive and that its staff of a few hundred investigators can conduct CRs on only approximately 3 percent of active motor carriers annually. Given the limited investigative resources available, ineffective use of those resources is troubling. The FMCSA has stated that it is working to expand the types and number of interventions used to reach more at-risk operators. The NTSB is concerned that while the FMCSA works to achieve this goal, its internal oversight may be lacking, both at the staff level, where violations in BASICs are not being documented by CRs, and at the management level, where reviews by federal program managers are not detecting substandard and incomplete investigative work.

The NTSB is aware that the FMCSA's authority to use imminent hazard OOS orders was expanded in 2012 by the Moving Ahead for Progress in the 21st Century Act (MAP-21) and recognizes that issuance of an imminent hazard order is dependent solely on the FMCSA's determination that a condition or on-going action is a significant and immediate safety hazard necessitating cessation of that carrier's operations. Moreover, the NTSB acknowledges that such orders may be issued independent of the CR process. The NTSB applauds the FMCSA's recent targeted actions to use its imminent hazard authority to remove unsafe operators from our roadways and strongly supports the expanded use of imminent hazard OOS orders. The NTSB also appreciates the FMCSA's development of "quick strike" capability by providing more than 50 specially trained safety investigators to target high-risk passenger carriers. However, despite these positive actions, the NTSB remains concerned that, based on the findings with respect to the inadequate CRs conducted on Mi Joo Tour & Travel and Scapadas Magicas LLC, some FMCSA safety investigators working in the field may need additional training, more specific work procedures, and better oversight.

¹⁶ These are the Western Service Center in Lakewood, Colorado; the Eastern Service Center in Glen Burnie, Maryland; the Midwestern Service Center in Matteson, Illinois; and the Southern Service Center in Atlanta, Georgia.

The FMCSA 2012–2016 Strategic Plan offers a high-level statement of the government requirements to measure programmatic effectiveness in accordance with the Government Performance and Results Act (GPRA) and the GPRA Modernization Act. The FMCSA regularly reports performance metrics of oversight work to Congress and uses focused work models, such as its Compliance Review Effectiveness Model, to estimate the numbers of crashes avoided and lives saved. Although such work metrics provide quantitative estimates of the effects of CRs in the aggregate,¹⁷ they do not necessarily address the quality of investigators' work.

On the basis of the deficiencies identified in the CRs conducted on Mi Joo Tour & Travel and Scapadas Magicas LLC, action is needed to identify the root cause of CR deficiencies and to incorporate more robust quality control systems into the CR process. Therefore, given the safety violations missed by FMCSA investigators in the precrash CRs of Mi Joo Tour & Travel and Scapadas Magicas LLC, the NTSB recommends that the US Department of Transportation (DOT) conduct an audit of the CR processes used by the FMCSA to determine (1) why inspectors are not identifying all violations of safety regulations by motor carriers undergoing review, and (2) why the FMCSA's quality assurance efforts are not fully effective in assessing the accuracy and completeness of CRs; once these determinations have been made, the DOT should require the FMCSA to revise its processes to correct these deficiencies.

Two Property Carrier Crashes and the On-Site Focused CRs Conducted on the Carriers Involved

Although poor quality investigative work by FMCSA investigators is a serious problem, it is not the only issue associated with CRs that has surfaced during recent NTSB investigations. Another area where improvement is needed concerns the nature of the on-site focused CRs that the FMCSA is increasingly using as the primary intervention of choice. Under the CSA program, FMCSA interventions can include the following types of early contact: warning letters, carrier access to safety data and measurement, and targeted roadside inspections. Investigative actions resulting from SMS information can include off-site investigations, on-site focused investigations (referred to in this document as "focused CRs"), and on-site comprehensive investigations. Two recent investigations—of property carrier crashes in Elizabethtown, Kentucky, and Murfreesboro, Tennessee—highlight the NTSB's concern with focused CRs.

Highway Star, Inc., Crash in Elizabethtown, Kentucky

The first case involved a truck-tractor semitrailer operated by a Troy, Michigan, carrier, Highway Star, Inc., which collided with two other vehicles on March 2, 2013, near Elizabethtown, Kentucky.¹⁸ A 2012 Kenworth truck-tractor in combination with a semitrailer was traveling northbound in the right lane of Interstate 65. A Ford Expedition sport utility vehicle (SUV) occupied by a 62-year-old male driver and seven passengers, ranging in age from 8 to 92, was also traveling northbound in the right lane in front of the combination vehicle. In response to a disabled vehicle that was broken down in the right shoulder, vehicles ahead of the Ford SUV

¹⁷ The Compliance Review Effectiveness Model compares a motor carrier's crash rate for the 12 months following an on-site CR to its crash rate for the 12 months preceding the CR. Results are reported by fiscal year (FY), and the most recent posting of such data is for FY 2008; for more information, see <http://ai.fmcsa.dot.gov/pe/PEReport.aspx?rp=crNat>, accessed October 28, 2013.

¹⁸ See HWY-13-FH-008 for more information.

had slowed, and a traffic queue had formed in the right lane of the interstate. The combination vehicle, which was traveling at a recorded speed of 67 mph, collided with the Ford SUV, pushing it into a 2007 Toyota Avalon. A postcrash fire consumed the Ford SUV. The 47-year-old driver of the combination vehicle reported to police that he “didn’t hit the brakes in time.” The crash resulted in fatal injury to six occupants of the Ford SUV. The two other occupants were transported to area hospitals for treatment of their injuries. The driver of the Toyota received minor injuries, and the driver of the combination vehicle was reportedly not injured.

In a postcrash inventory of the truck-tractor, the Kentucky State Police located the driver’s logbook pages, in which the driver recorded that he had been off duty February 18–25, 2013. No other logbook pages were found at that time. The NTSB requested the driver’s logbook pages from the carrier, Highway Star, and received matching records. A subsequent search of the truck-tractor revealed a second set of logbook pages in which the driver recorded trips from February 21 through the crash date of March 2, 2013. These trips were continuous and had no off-duty days (that is, no 34-hour reset time). This second set of records also indicated that the crash driver had been driving for 10 consecutive days and was in violation of the 70-hour rule.¹⁹ A review of his sleep/wake/work profile and cell phone records indicated that he was most likely fatigued at the time of the crash, which could provide an explanation for his delayed reaction to the traffic queue slowed in front of him.

The FMCSA had previously conducted oversight actions on the motor carrier, Highway Star. After passing a New Entrant Program safety audit (conducted on July 13, 2005), the carrier received two CRs (on October 25, 2007, and February 26, 2010); both resulted in Satisfactory ratings. Highway Star also received a focused CR on February 26, 2013, the same week as the fatal crash, because the carrier had an SMS alert in the Unsafe Driving BASIC. From the end of 2010 to the beginning of 2013, Highway Star had SMS alerts in the Unsafe Driving BASIC; the carrier also had alerts in the HOS BASIC. The 2013 focused CR looked only at the Unsafe Driving BASIC, and it had a Non-Rated outcome. This focused CR, conducted 5 days prior to the crash, did not consider driver HOS records because it was predicated on an SMS alert associated with the Unsafe Driving BASIC. This restrictive review was conducted despite the fact that each of the previous CRs conducted on Highway Star found driver-related violations, including driver HOS violations and driver vehicle inspection report (DVIR) violations.²⁰

The NTSB investigation of Highway Star’s operations following the fatal March 2013 crash examined five driver qualification files: each included at least one “critical” violation. Of the five files examined, three had no DVIRs for periods as long as a month, during which time the drivers were concurrently being paid for making freight trips. In addition to reviewing the driving records of the Elizabethtown crash driver, NTSB investigators reviewed the driver logbooks and pay records for seven other Highway Star drivers. Records for the crash driver and another driver revealed that they each had two differing sets of driver logbooks: in both cases, the drivers were found to have violated the 70-hour driving rule. Further, by comparing pay records, gas receipts, roadside inspection records, and travel time for work conducted during January and February 2013, NTSB investigators found falsified records for all eight drivers. The

¹⁹ From February 26 through March 2, 2013, the crash driver had driven 72.75 hours, in violation of the 70-hour rule. HOS violations are “critical” violations for both driver and carrier, per 49 CFR 395.3(b)(2).

²⁰ HOS requirements are covered in 49 CFR Part 395, and DVIRs are covered in 49 CFR Part 396.

evidence showed that the carrier routinely scheduled its drivers to make delivery trips that required them to violate HOS regulations.

Following the NTSB investigation of Highway Star, the FMCSA conducted another CR of the carrier, which resulted in an Unsatisfactory rating. The specific violations resulting in the Unsatisfactory determination were in factor 3 concerning 49 CFR 395.8(e), as follows: "False reports of records of duty status 395.8(i)—Failure to require a driver to forward within 13 days of completion, the original of the record of duty status." The postcrash CR noted eight other violations of the *Federal Motor Carrier Safety Regulations* (FMCSRs); however, none of these violations were classed as either "acute" or "critical," so they did not adversely affect the carrier's rating. As a result of the postcrash CR, on March 21, 2013, the FMCSA issued an imminent hazard OOS order to Highway Star and the crash driver. The FMCSA cited a series of driver-related violations as the reason for the OOS order. Specifically, the FMCSA stated that

HIGHWAY STAR, INC. currently permits or requires its drivers who operate commercial motor vehicles in interstate commerce to falsify their records of duty status, and fails to preserve records of duty status, which means HIGHWAY STAR, INC. is unable to monitor its drivers' compliance with regulations pertaining to maximum hours of service and required off-duty and rest hours.²¹

As has been noted, however, the FMCSA had evidence long before the crash, via roadside inspection and CR information, that Highway Star had a history of HOS violations. Nevertheless, it took no significant action against the carrier for such violations before the fatal crash took place.

H & O Transport, Inc., Crash in Murfreesboro, Tennessee

A second, similar NTSB investigation involved a truck-tractor in combination with a semitrailer operated by the Louisville, Kentucky, carrier H & O Transport, Inc., which collided with eight other vehicles on June 13, 2013, approximately 12:10 a.m. central daylight time, near Murfreesboro, Tennessee.²² A short time earlier that night, a two-vehicle traffic collision occurred in the eastbound lanes of Interstate 24 near exit 81. Due to that collision, slow-moving traffic had formed in both eastbound lanes. According to the 40-year-old H & O Transport truck driver, he was observing traffic to his left and wanted to merge because the number of lanes was reducing from three to two. The driver said he was traveling 55–60 mph when he saw that traffic had stopped. He applied the brakes and took evasive action but struck the traffic queue in front of him. The collisions that resulted caused 2 fatalities in a 2003 Honda that overturned and was consumed in a postcrash fire; 6 of the 13 occupants of the other eight vehicles struck by the truck-tractor semitrailer were injured.²³

H & O Transport began operation in 1982 with two trucks and two drivers. At the time of the crash, the carrier operated 33 truck-tractors and 80 semitrailers, and employed 32

²¹ See Imminent Hazard Operations Out-of-Service Order MI-2013-5001-IMH, issued March 21, 2013.

²² See HWY-13-FH-015 for more information.

²³ The eight vehicles in order of impact were a 1999 Oldsmobile, 2003 Honda, 2003 Toyota, 2006 Kia, 2001 Chevrolet, 2007 Chevrolet, 2002 Jeep, and 2013 Freightliner.

commercially licensed drivers.²⁴ The company drivers were “leased” drivers paid by the mile.²⁵ The carrier had one full-time company-employed mechanic and one full-time contract mechanic.

The H & O Transport crash driver had departed Louisville, Kentucky, about 10:00 p.m. on June 12, 2013, en route to Tullahoma, Tennessee. A review of the driver’s logs indicated that he was in violation of the 70-hour driving rule (49 CFR 395.8) by 9.75 hours on June 11, 2013, and by 45 minutes at the time of the crash. The driver’s slowed reaction to traffic changes in the early morning hours and his excessive driving schedule indicate that he was most likely fatigued at the time of the crash. With respect to HOS behavior, this driver was far from unique in H & O Transport’s operations. The NTSB investigation reviewed the driver logbook history for the crash driver and four additional drivers in the months preceding the crash. Investigators identified 14 HOS violations and another 5 potential HOS violations.²⁶ Investigators examined 386 logbook pages for March 1 through June 11, 2013; of the 386 pages, a total of 134 (35 percent) contained false log entries, as determined by evidence from fuel receipts and driving times.

At the time of the crash, the carrier’s Inspection Selection System (ISS) score was 87, placing it in the “Inspect” category.²⁷ According to the FMCSA Safety and Fitness Electronic Records (SAFER) data,²⁸ the carrier had 117 roadside inspections in the 24 months prior to July 3, 2013. From April 2012 through May 2013, the carrier was the subject of 19 roadside inspections in which drivers were cited for logbook violations. Those roadside inspections resulted in 24 violations and 9 driver OOS orders. From November 2010 to May 2013, H & O Transport had HOS BASIC SMS alerts in effect more than half the time (for 18 of 30 months).

Prior to the 2013 crash, the carrier underwent four full CRs and one focused CR on the following dates, resulting in the following ratings: 1991, Conditional; 1996, Conditional; 2001, Satisfactory; 2009, Satisfactory; and 2011 (focused CR on the Unsafe Driving BASIC), Non-Rated. The carrier was subject to a postcrash CR on June 17, 2013, that was completed on June 26, 2013; the CR rating was Conditional.²⁹ The 2011 focused CR had been initiated due to the carrier’s alerts in the Unsafe Driving BASIC. The NTSB considers that the fact that H & O

²⁴ The majority of those commercial drivers (23 of 32) operated on routes that required them to complete logbooks. Per 49 CFR 395.1(e), drivers operating within a 100-air-mile radius of the home terminal (“short haul” or “local”) are not required to complete a record of duty status (logbook). Instead they must meet specific work time and pay record requirements.

²⁵ The carrier contracted with a private screening company that processed and hired its job applicants. Newly hired drivers were assigned to work full time for the carrier, which paid the screening company a fee to continue to monitor the drivers’ activities for compliance with the FMCSRs. The drivers were paid directly by the carrier by the mile.

²⁶ Characterization of “potential” HOS violations is necessary due to insufficient information to calculate exact driving time, but corroborating evidence indicated that the driver probably exceeded HOS limits.

²⁷ ISS is the primary software tool supported by the FMCSA for use at the roadside to screen commercial motor vehicles for inspection. It provides carrier identification data and an overall inspection value from 1 to 100, with 1 being best and 100 being worst. In the ISS, carriers are rated “Inspect,” “Optional,” and “Pass.”

²⁸ See <http://safer.fmcsa.dot.gov/>, accessed July 4, 2013.

²⁹ The rating was based on HOS and other violations of Part 395, resulting in an Unsatisfactory rating in factor 3—Operational, and based on violations in operations and maintenance, Parts 393 and 396, resulting in a Conditional rating in factor 4.

Transport's history of HOS violations was not also considered during the 2011 focused CR constituted a missed opportunity to improve carrier safety.

Concerns About Focused CRs

The NTSB is aware that with the advent of the CSA program, the FMCSA has an expanded set of interventions, including focused reviews that evaluate only an identified area of the carrier's operation based on a data-driven analysis. The FMCSA's oversight of Highway Star and H & O Transport illustrates one of the shortcomings of focused investigations: violations in business operations that are not in areas identified for oversight review are not considered. For carriers that have a history of violations in more than one BASIC area, limiting the intervention to a focused CR is an obvious shortcoming in compliance oversight. With an expanded set of oversight intervention options, the FMCSA will need to work diligently to ensure that the appropriate options are being applied to ensure the safety of selected operators.

The FMCSA is expanding its use of focused CRs. In addition to approximately 7,600 carrier reviews conducted by the states, the FMCSA conducted 11,086 CRs of all types in FY 2011; 12,366 in FY 2012; and, based on 9 months of preliminary data, an estimated 10,130 in FY 2013.³⁰ The proportion of those CRs that were focused CRs—limited to identified BASIC areas of deficiency—for those same periods was 4,252 in FY 2011 (38 percent); 7,191 in FY 2012 (58 percent); and an estimated 6,344 in FY 2013 (63 percent). Thus, nearly two-thirds of CRs are now limited to a designated BASIC compliance area. Although a focused CR may be an appropriate intervention when operational deficiencies show up in one BASIC area, use of this restricted intervention for carriers with a history of violations in several BASIC areas seems inappropriate.

As the FMCSA intervention process changes to include limited investigations that focus solely on a specific SMS area, the NTSB is concerned with how the agency ensures that these reviews have sufficient scope. In fact, it seems likely that a carrier's noncompliance in one area might be an indicator of operational problems in other areas. The FMCSA Administrator has testified before Congress that the agency's newly implemented CSA system has changed the investigative process so that "Federal and State safety investigators are trained not just to identify violations, but also to identify the root cause of the safety deficiency and review these root causes with carrier officials."³¹ This statement, however, is not borne out by the focused CRs the FMCSA conducted on the operations of Highway Star and H & O Transport—two carriers whose most recent interventions were focused CRs. Because their scope was limited solely to the SMS area that was flagged with an alert when the review was conducted, these focused CRs failed to consider important safety deficiencies at both carriers, which raises the practical question of whether focused reviews may constitute a missed opportunity to address safety deficiencies in a motor carrier's operations.

It appears that a focused CR may enable an unsafe operator to continue to operate while violating safety regulations despite FMCSA oversight, if it manages to address the one highlighted safety deficiency area that prompted the focused CR, while ignoring others that may

³⁰ This information is based on the FMCSA Motor Carrier Safety Progress Report (as of June 30, 2013). See <http://www.fmcsa.dot.gov/facts-research/art-safety-progress-report.htm>.

³¹ Statement of FMCSA Administrator Anne S. Ferro before the Subcommittee on Highways and Transit, Committee on Transportation and Infrastructure, US House of Representatives, September 13, 2012.

be equally significant. The NTSB understands that FMCSA investigators are directed to remain within the scope of the BASIC identified by the SMS when conducting a focused investigation. Although the FMCSA may allow its investigators some latitude to address violations outside of the originally assigned BASIC area, the discovery of such violations cannot be used to expand the overall scope of a focused CR. Consequently, when such safety violations are discovered during a focused CR, the range of available action against the carrier is limited.

The NTSB is aware that the DOT's Office of Inspector General (IG) currently has a project underway with a goal of assessing the effectiveness of CSA enforcement interventions. The NTSB would expect that IG audit to consider the effectiveness of focused CRs, and based on the findings, would expect the FMCSA to evaluate, and revise as necessary, CR policies that restrict investigators involved in focused CRs from identifying and taking effective action to address safety deficiencies in other BASIC areas.

Because the focused CR interventions proved to be too narrow in scope to identify and address driver problems with the carriers Highway Star and H & O Transport, the NTSB recommends that the DOT conduct an audit of the effectiveness of focused CRs and, upon the completion of the audit, require the FMCSA to take action to resolve any safety issues raised by the audit.

Therefore, the NTSB makes the following recommendations to the US Department of Transportation to address the oversight issues raised by the four highway crashes discussed in this letter:

Conduct an audit of the compliance review processes used by the Federal Motor Carrier Safety Administration (FMCSA) to determine (1) why inspectors are not identifying all violations of safety regulations by motor carriers undergoing review, and (2) why the FMCSA's quality assurance efforts are not fully effective in assessing the accuracy and completeness of compliance reviews; once these determinations have been made, require the FMCSA to revise its processes to correct these deficiencies. (H-13-039)

Conduct an audit of the effectiveness of focused compliance reviews and, upon the completion of the audit, require the Federal Motor Carrier Safety Administration to take action to resolve any safety issues raised by the audit. (H-13-040)

Chairman HERSMAN, Vice Chairman HART, and Members SUMWALT, ROSEKIND, and WEENER concurred in these recommendations.

The NTSB is vitally interested in these recommendations because they are designed to prevent crashes and save lives. We would appreciate receiving a response from you within 90 days detailing the actions you have taken or intend to take to implement them. When replying, please refer to the safety recommendations by number. We encourage you to submit your response electronically to correspondence@ntsb.gov.

By: Deborah A.P. Hersman
[Original signed]



THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

February 3, 2014

The Honorable Deborah A. P. Hersman
Chairman
National Transportation Safety Board
490 L'Enfant Plaza East, SW
Washington, DC 20594

Dear Chairman Hersman:

I am pleased to send you this letter in response to Safety Recommendations H-13-039 and H-13-040, which were issued on November 5, 2013, following the Board's investigation of four recent commercial motor vehicle crashes. Safety is the number one priority of the U.S. Department of Transportation (DOT) and we are focused on appropriately addressing all of the safety recommendations in your report.

The NTSB recommended that the Secretary:

- Conduct an audit of the compliance review processes used by the Federal Motor Carrier Safety Administration (FMCSA) to determine (1) why inspectors are not identifying all violations of safety regulations by motor carriers undergoing reviews, and (2) why the FMCSA's quality assurance efforts are not fully effective in assessing the accuracy and completeness of compliance reviews; and, once these determinations have been made, to require the FMCSA to revise its processes to correct these deficiencies (H-13-039).
- Conduct an audit of the effectiveness of focused compliance reviews and, upon completion of the audit, require the FMCSA to take action to resolve any safety issues raised by the audit (H-13-040).

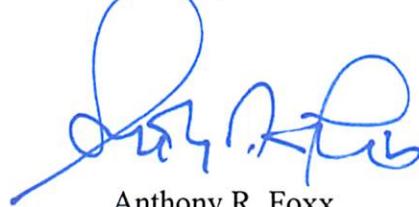
Immediately following the motorcoach crashes referenced in your report, the FMCSA initiated a thorough review of its compliance investigation process to assess gaps and identify corrective action. The result is a comprehensive strategy that includes enhanced investigator training, dedicated resources focused on the highest-risk motorcoach companies, and a top-to-bottom analysis of its current passenger carrier oversight authority and resources.

In response to your recommendations, I have tasked the Department's Safety Council to oversee an independent review of the FMCSA's compliance review process. The Safety Council is composed of the heads of each DOT modal administration, their senior safety officers, and senior officials from the Office of the Secretary. This group is responsible for leading change in the Department's safety culture by breaking down organizational silos and leveraging best safety

practices throughout the Department. The Federal Aviation Administration's Office of Aviation Safety will play a key role in this effort, as they have expertise in this type of review. We will share the results of this review with you upon completion.

If I can provide further information or assistance, please feel free to call me.

Sincerely,

A handwritten signature in blue ink, appearing to read "Anthony R. Foxx", is written over a light blue horizontal line. The signature is stylized and cursive.

Anthony R. Foxx

Appendix 10: Tasking Letters and MOA



THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

April 11, 2014

Mr. William Voss
Deputy Director
Air Traffic Safety Oversight Service
Federal Aviation Administration
800 Independence Avenue, SW
Washington, DC 20591

Dear Mr. Voss:

Thank you for your willingness to serve on the Independent Review Team (IRT) that will address National Transportation Safety Board (NTSB) safety recommendations H-12-039 and H-13-040 regarding the Federal Motor Carrier Safety Administration (FMCSA). I am enclosing the Memorandum of Agreement between FMCSA and the Federal Aviation Administration, a tasking statement outlining the expected work, and a list of the IRT members.

I expect that the IRT will provide actionable information and recommendations to respond to the NTSB. I also see the IRT as providing insights and perspectives in the broader context of FMCSA and its environment.

I have sent similar letters to each of member of the IRT listed in the enclosures. I look forward to working with the IRT and helping you in any way necessary to carry out this objective.

Sincerely,

A handwritten signature in black ink, appearing to read "Anthony R. Foxx", is written over the word "Sincerely,". The signature is fluid and cursive, with a long horizontal stroke extending to the left.

Anthony R. Foxx

Enclosures



THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

April 11, 2014

Mr. Charles Raley
Office of the Chief Counsel, AGC-300
Federal Aviation Administration
800 Independence Avenue, SW
Washington, DC 20591

Dear Mr. Raley:

Thank you for your willingness to serve on the Independent Review Team (IRT) that will address National Transportation Safety Board (NTSB) safety recommendations H-12-039 and H-13-040 regarding the Federal Motor Carrier Safety Administration (FMCSA). I am enclosing the Memorandum of Agreement between FMCSA and the Federal Aviation Administration, a tasking statement outlining the expected work, and a list of the IRT members.

I expect that the IRT will provide actionable information and recommendations to respond to the NTSB. I also see the IRT as providing insights and perspectives in the broader context of FMCSA and its environment.

I have sent similar letters to each of member of the IRT listed in the enclosures. I look forward to working with the IRT and helping you in any way necessary to carry out this objective.

Sincerely,

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Anthony R. Foxx

Enclosures



THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

April 11, 2014

Dr. Jacqueline Duley
TASC, Inc.
475 School Street, SW
Washington, DC 20024

Dear Dr. Duley:

Thank you for your willingness to serve on the Independent Review Team (IRT) that will address National Transportation Safety Board (NTSB) safety recommendations H-12-039 and H-13-040 regarding the Federal Motor Carrier Safety Administration (FMCSA). I am enclosing the Memorandum of Agreement between FMCSA and the Federal Aviation Administration, a tasking statement outlining the expected work, and a list of the IRT members.

I expect that the IRT will provide actionable information and recommendations to respond to the NTSB. I also see the IRT as providing insights and perspectives in the broader context of FMCSA and its environment.

I have sent similar letters to each of member of the IRT listed in the enclosures. I look forward to working with the IRT and helping you in any way necessary to carry out this objective.

Sincerely,

A handwritten signature in black ink, appearing to read 'Anthony R. Foxx', with a long horizontal line extending to the left.

Anthony R. Foxx

Enclosures



THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

April 11, 2014

Mr. William O. McCabe
The McCabe Group, LLC
41 Harris Circle
Newark, DE 19711

Dear Mr. McCabe:

Thank you for your willingness to serve on the Independent Review Team (IRT) that will address National Transportation Safety Board (NTSB) safety recommendations H-12-039 and H-13-040 regarding the Federal Motor Carrier Safety Administration (FMCSA). I am enclosing the Memorandum of Agreement between FMCSA and the Federal Aviation Administration, a tasking statement outlining the expected work, and a list of the IRT members.

I expect that the IRT will provide actionable information and recommendations to respond to the NTSB. I also see the IRT as providing insights and perspectives in the broader context of FMCSA and its environment.

I have sent similar letters to each of member of the IRT listed in the enclosures. I look forward to working with the IRT and helping you in any way necessary to carry out this objective.

Sincerely,

A handwritten signature in black ink, appearing to read 'Anthony R. Foxx', is written over a large, stylized loop. The signature is positioned above the printed name 'Anthony R. Foxx'.

Anthony R. Foxx

Enclosures



THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

April 11, 2014

Mr. Neil Eisner
6356 Lakeview Drive
Falls Church, VA 22041

Dear Mr. Eisner:

Thank you for your willingness to serve on the Independent Review Team (IRT) that will address National Transportation Safety Board (NTSB) safety recommendations H-12-039 and H-13-040 regarding the Federal Motor Carrier Safety Administration (FMCSA). I am enclosing the Memorandum of Agreement between FMCSA and the Federal Aviation Administration, a tasking statement outlining the expected work, and a list of the IRT members.

I expect that the IRT will provide actionable information and recommendations to respond to the NTSB. I also see the IRT as providing insights and perspectives in the broader context of FMCSA and its environment.

I have sent similar letters to each of member of the IRT listed in the enclosures. I look forward to working with the IRT and helping you in any way necessary to carry out this objective.

Sincerely,

A handwritten signature in black ink, appearing to read 'A. R. Foxx', is written over a large, stylized loop that extends from the word 'Sincerely'.

Anthony R. Foxx

Enclosures



THE SECRETARY OF TRANSPORTATION
WASHINGTON, D.C. 20590

April 11, 2014

Ms. Lynne B. Judd
1006 Grant Street
Madison, WI 53711

Dear Ms. Judd:

Thank you for your willingness to serve on the Independent Review Team (IRT) that will address National Transportation Safety Board (NTSB) safety recommendations H-12-039 and H-13-040 regarding the Federal Motor Carrier Safety Administration (FMCSA). I am enclosing the Memorandum of Agreement between FMCSA and the Federal Aviation Administration, a tasking statement outlining the expected work, and a list of the IRT members.

I expect that the IRT will provide actionable information and recommendations to respond to the NTSB. I also see the IRT as providing insights and perspectives in the broader context of FMCSA and its environment.

I have sent similar letters to each of member of the IRT listed in the enclosures. I look forward to working with the IRT and helping you in any way necessary to carry out this objective.

Sincerely,

A handwritten signature in black ink, appearing to read 'Anthony R. Foxx', is written over a large, stylized circular flourish.

Anthony R. Foxx

Enclosures

MEMORANDUM OF AGREEMENT

BETWEEN THE FEDERAL AVIATION ADMINISTRATION AND THE FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION

Parties:

This Memorandum of Agreement (MOA or Agreement) is between the Federal Aviation Administration (FAA) and the Federal Motor Carrier Safety Administration (FMCSA), collectively referred to as Parties.

Introduction:

In a letter addressed to the Chair of the National Transportation Safety Board (NTSB), the Office of the Secretary (OST) tasked the Department of Transportation (DOT) Safety Council to oversee an independent review of the Federal Motor Carrier Safety Administration's (FMCSA) compliance review process. This review is in response to NTSB recommendations, H-13-039 and 040, surrounding recent commercial motor vehicle crashes. The Federal Aviation Administration (FAA), as a peer of FMCSA, will conduct the review.

H-13-039 and -040	Independent Review Team (IRT) Mission
<p>Conduct an audit of the compliance review process used by the FMCSA to determine:</p> <ul style="list-style-type: none">• Why inspectors are not identifying all violations of safety regulations by motor carriers undergoing review• Why the FMCSA's quality assurance efforts are not fully effective in assessing the accuracy and completeness of compliance reviews <p>Conduct an audit of the effectiveness of focused compliance reviews</p>	<p>The IRT will conduct a review to determine:</p> <ul style="list-style-type: none">• How investigators can more effectively identify violations of safety regulations on the carrier and vehicle specific undergoing review• How FMCSA quality assurance efforts can be more effective in assessing the accuracy and completeness of compliance reviews• What criteria determines whether a focused review is scheduled• Who and what determines if a focused review is changed to a comprehensive review

Authority:

The Secretary of Transportation authorized this assessment under the authority of 49 U.S.C. § 31133, which grants general powers to the Secretary of Transportation to improve motor carrier, commercial motor vehicle, and driver safety to support a safe and efficient transportation system.

Scope and Requirements:

Upon execution of this agreement, FAA will establish an independent review team (IRT). The FAA will provide approximately 1.5 full time equivalents to the IRT. This will include a dedicated executive team lead with extensive intermodal safety expertise, legal counsel with enforcement experience, a data management expert, and a regulatory expert. As part of this effort the FAA will contract with an outside vendor who will provide access to specialized external expertise and provide logistical and technical support.

The contractor will provide assistance to the independent review team with tasks such as, but not limited to, logistical and other support with the development of reports and briefings. The contractor will be responsible for the retention and maintenance of all documentation generated or gathered by the independent review team. The FAA administrative support and contract oversight will also be provided as required.

The IRT will also include members who are independent from the DOT and have similar experience with these types of reviews in various modes of transportation. Appendix A provides more details of the IRT members' experience.

The objectives of the IRT are to:

- A. Collect, analyze, and evaluate data collected from discussions with FMCSA headquarters and field personnel to develop appropriate recommendations for DOT response to NTSB
- B. Develop recommendations for other opportunities identified during the course of the IRT effort to improve motor carrier safety.

The IRT will develop a detailed understanding of the Compliance, Safety, Accountability (CSA) program, the Behavior Analysis and Safety Improvement Categories (BASICS) and their role in prioritization, and how the Compliance Review process works to determine whether specific elements compromise effectiveness in order to identify changes that may improve motor carrier safety. During the conduct of the review, factors such as culture, delegation, resource levels, and shared authority with states, will merit consideration.

The IRT will conduct the following phases of review to address the NTSB recommendations.

Phase 1: Initial Review

The IRT will refine the scope of the review through meetings with OST, FMCSA Headquarters staff, exploratory discussions with Division Administrators with the Eastern Service Center, and reviews of relevant NTSB, Government Accountability Office (GAO), and Office of the Inspector General (OIG) studies and analyses.

Phase 2: The FMCSA Environmental Scan

The objective is to gather perspectives and additional information to refine the IRT areas of interest around the FMCSA compliance review process conducted by the FMCSA field operations teams. In this phase, the IRT will meet with the DOT Safety Council, NTSB, Government Accountability Office (GAO), and Office of the Inspector General (OIG) as well as relevant industry stakeholders to gain an understanding of areas that may or may not contribute to the effectiveness of FMCSA compliance reviews.

Additionally during this phase, a one-day seminar will be conducted to further inform the IRT and other FMCSA participants of best practices and potential pitfalls in the transformation of regulatory oversight from compliance based to risk based oversight. These best practices and pitfalls will be used to further guide and refine the IRT's efforts.

Phase 3: The FMCSA Field Review

During Phase 3, the IRT will conduct discussions and observations with supervisory and front line staff in at least two division offices with FMCSA concurrence. The objective for this phase is to verify that the implementation of the CSA interventions is in line with the original intentions and to understand the field perspective on the execution of the compliance review process. The IRT will explore how the investigators can more effectively identify violations of safety regulations by the carrier and vehicle specifically undergoing review. Additionally, the IRT will discuss with Division personnel how FMCSA quality assurance efforts can be more effective in assessing the accuracy and completeness of compliance reviews.

Phase 4: Analysis, Findings, and Recommendations

During this final phase, the IRT will synthesize data and information gathered, develop themes for the findings, and provide actionable recommendations to FMCSA.

Specifically, the IRT will provide

- A. Recommendations for addressing the NTSB,
- B. Recommendations and insights for optimizing the effectiveness of interventions related to policy, structure, culture, process, technology and data, and
- C. Identification of existing building blocks of success, means of filling identified gaps, and new opportunities for improved safety

Recommendations will be provided in a Final Written Report and in briefings upon FMCSA request.

Funding: and Estimated Costs:

The Parties will address funding in an Intragency Agreement (IAA), authorized under the Economy Act, 31 U.S.C. § 1535 and/or such other legal authorities as the Parties may mutually deem appropriate. This MOA is not a funding obligation document. Nothing in this Agreement shall commit either Party to incur costs of services in violation of the Anti-Deficiency Act, 31 U.S.C. § 1341.

Interpretations, Changes, and Modifications:

All requests for interpretation of the language or provisions of this MOA shall be made in writing. Changes and/or modifications to this MOA must be in writing and signed by the FAA signing official and the FMCSA signing official, their successors, or their authorized representatives. The Parties may supplement this MOA and may enter into subsequent Agreements to further define particular services and procedures.

Disputes and Conflicts:

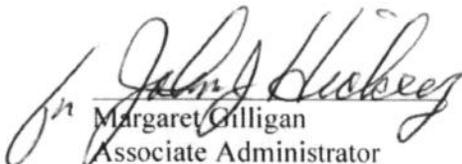
The Parties agree to take immediate action to resolve issues and disputes that arise from the implementation of this Agreement. The Parties agree that disputes should be resolved at the lowest possible managerial level. Where possible, disputes regarding implementation of the provisions of this MOA will be resolved by informal discussion between the Parties implementing its terms, or between officials higher in their respective departments. Unresolved disputes regarding MOA terms and interpretation will subsequently be submitted for resolution to the Administrator of the FMCSA or her authorized representative and the position equivalent of Administrator of the FAA or his authorized representative.

Effective Date:

This MOA becomes effective upon the signatures of both Parties.

Final product:

The independent review team will submit a report to the Secretary no later than June 15, 2014.


Margaret Gilligan
Associate Administrator
For Aviation Safety, FAA

3/5/14
Date

John Van Steenburg
Assistant Administrator and
Chief Safety Officer, FMCSA

Date

Interpretations, Changes, and Modifications:

All requests for interpretation of the language or provisions of this MOA shall be made in writing. Changes and/or modifications to this MOA must be in writing and signed by the FAA signing official and the FMCSA signing official, their successors, or their authorized representatives. The Parties may supplement this MOA and may enter into subsequent Agreements to further define particular services and procedures.

Disputes and Conflicts:

The Parties agree to take immediate action to resolve issues and disputes that arise from the implementation of this Agreement. The Parties agree that disputes should be resolved at the lowest possible managerial level. Where possible, disputes regarding implementation of the provisions of this MOA will be resolved by informal discussion between the Parties implementing its terms, or between officials higher in their respective departments. Unresolved disputes regarding MOA terms and interpretation will subsequently be submitted for resolution to the Administrator of the FMCSA or her authorized representative and the position equivalent of Administrator of the FAA or his authorized representative.

Effective Date:

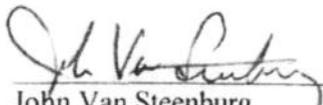
This MOA becomes effective upon the signatures of both Parties.

Final product:

The independent review team will submit a report to the Secretary no later than June 15, 2014.

Margaret Gilligan
Associate Administrator
For Aviation Safety, FAA

Date



John Van Steenburg
Assistant Administrator and
Chief Safety Officer, FMCSA

3/5/2014
Date

Appendix A.

Organization	Brief Description of Expertise
FAA	<ul style="list-style-type: none"> • Deputy Director of FAA Air Traffic Safety Oversight. Member of the executive team responsible for the regulation and safety oversight of U.S. air traffic control system • Special assignment to Federal Transit Administration to assist in the establishment of new MAP-21 safety oversight system • CEO of Flight Safety Foundation, recognized as an international expert on safety management systems and safety oversight. Served as an advisor to multiple aviation regulatory authorities • Senior official at International Civil Aviation Organization. Responsible for the development of international aviation safety standards, and for the implementation of these standards into 189 international aviation regulatory systems
FAA	<ul style="list-style-type: none"> • FAA attorney, Office of the Chief Counsel, Enforcement Division • US Naval Aviator, 1994-2005 • Extensive experience in aviation and ground safety programs
FAA	<ul style="list-style-type: none"> • Additional FAA support to include expertise in air traffic safety oversight, regulations, and research and analysis

Organization	Brief Description of Expertise
Independent	<ul style="list-style-type: none"> • Founder of leadership and safety culture consultancy, 2006—Present • Member, Blue Ribbon Panel appointed by Secretary of Transportation, Mary Peters, to review the FAA's Approach to Safety, May-September, 2008 • Selected by WMATA Board of Directors to provide operational safety leadership analysis/guidance for WMATA's senior management and rail and bus workforce
Independent	<ul style="list-style-type: none"> • Consultant on a variety of administrative law matters, including regulatory compliance issues • US DOT Assistant General Counsel for Regulation and Enforcement, 1978 – 2013 • FAA Deputy Assistant Chief Counsel for Litigation
Independent	<ul style="list-style-type: none"> • Wisconsin's Motor Vehicle administrator 2005-2013 • Managed highway program field operations for Wisconsin DOT, 2001-2005 • Past board chair of the AAMVA • Active member of the Standing Committee on Highway Traffic Safety for AASHTO
Independent	<ul style="list-style-type: none"> • Professor of the Practice of Public Management at Harvard's John F. Kennedy School of Government • Faculty Chair of the school's executive program "Strategic Management of Regulatory and Enforcement Agencies" • Served 10 years with the British Police Service, rising to the rank of Detective Chief Inspector • Member, Blue Ribbon Panel appointed by Secretary of Transportation, Mary Peters, to review the FAA's Approach to Safety, May-September, 2008

Tasking Statement

To address NTSB Safety Recommendations H-13-039 and H-13-040, the IRT will conduct a review to determine:

- How investigators can more effectively identify violations of safety regulations on the carrier and vehicle undergoing review;
- How FMCSA quality assurance efforts can be more effective in assessing the accuracy and completeness of compliance reviews;
- How FMCSA quality assurance efforts can be more effective in assessing the accuracy and completeness of compliance reviews;
- What criteria determines whether a focused review is scheduled; and
- Who and what determines if a focused review is changed to a comprehensive review.

The IRT will collect, analyze, and evaluate data collected from discussions with FMCSA headquarters and field personnel to develop appropriate recommendations for DOT's response to NTSB. The IRT will also develop recommendations for other opportunities identified in the course of the IRT effort to improve motor carrier safety.

The IRT recommendations are due no later than June 15, 2014.

IRT Members

Member	Organization
Bill Voss	FAA
Charles Raley	FAA
Additional Support <ul style="list-style-type: none">• Jacqueline Duley (contractor support from TASC Inc.)	FAA

Bill McCabe	Independent
Neil Eisner	Independent
Lynne Judd	Independent

