Statement of Steve Owings, Father of Cullum Owings,

Killed in a Truck Crash Involving an Inattentive and Speeding Trucker

And

President and Co-Founder, Road Safe America (RSA)

Before the Subcommittee on Highways and Transit

Committee on Transportation and Infrastructure

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Good morning Chairman Duncan, Ranking Member DeFazio, and Members of the Subcommittee on Highways and Transit, of the Committee on Transportation and Infrastructure. I am Steve Owings, President and Co-Founder, with my wife Susan, of Road Safe America (RSA) which we formed after our son Cullum was killed in a crash caused by a speeding tractor trailer in 2002. I also serve as a member of the Federal Motor Carrier Safety Administration's (FMCSA) Motor Carrier Safety Advisory Committee (MCSAC) along with representatives from the motor carrier industry, safety organizations, and the law enforcement sector. I am speaking today on behalf of Road Safe America, the Truck Safety Coalition (TSC), Parents Against Tired Truckers (P.A.T.T.), and Citizens for Reliable and Safe Highways (CRASH). These safety organizations are committed to improving truck safety and making America's roads safer. Together with surviving families and friends, we all work on behalf of the tens of thousands of people who become victims of preventable truck crashes each year. Thank you for the opportunity to testify before you today on the Federal Motor Carrier Safety Administration's (FMCSA) Compliance, Safety, Accountability (CSA) Program.

Introduction and Support for CSA Program

The CSA Program was created to address the need to utilize all data more quickly to focus the FMCSA's limited resources on intervention with high risk carriers in order to prevent truck crashes and the resulting deaths and injuries. It is a significant improvement over the previous SafeStat Program which it replaced in December 2010. As changes continue to be considered and made to hone the CSA Program, it is essential that the Program retains the ability to efficiently analyze data for timely intervention, that it is cost effective given FMCSA's limited resources, and that it remains fair to truck crash victims and their surviving family and friends. Our volunteers have first-hand experience with the devastating consequences of truck crashes

and appreciate the truck safety improvements resulting from the CSA Program. We support the CSA Program and FMCSA's ongoing efforts toward fulfilling its Congressional mandate to save lives and prevent injuries by improving the safety of commercial motor vehicles.

In a recent MCSAC meeting, CSA benefits were discussed and committee members noted that the system "is dispensing more data and giving the agency the ability to reach more carriers without a dramatic increase in resources" and inspiring "the start of a cultural change in the industry by forcing carriers to focus on the details of safety management" (http://www.truckinginfo.com/news/news-detail.asp?news_id=77855). Independent analysis indicates MCSAC's assessment is accurate and that the CSA Program is a significant improvement over the prior system. Several key points from FMCSA's own evaluation include:

- CSA is effectively monitoring the industry with an interventions model that demonstrates an overall 35 percent increase in the number of carriers reached per Safety Investigator;
- From the CSA rollout in December 2010 until the end of 2011, violations per roadside inspection declined by eight percent and driver violations per inspection declined by 12 percent;
- Compliance improved while being less intrusive and time-consuming for all motor carriers (both large and small); and,
- An overwhelming majority (93 percent) of small carriers do not score poorly in any area of the CSA Safety Measurement System (SMS), supporting the CSA Program's lack of bias against small carriers (FMCSA Testimony, House Small Business Committee, July 11, 2012).

These results show the most significant improvement in violation rates in the last 10 years. The advances achieved with the CSA program are necessary and long overdue and should not be modified in ways that will hinder their effectiveness. My testimony will comment on changes being considered to crash data maintained within the CSA Crash BASIC, thresholds for intervention and the intervention process, greater transparency, and the necessity of preserving public access to information.

Cullum and Pierce Owings' Truck Crash

My family's involvement in truck safety advocacy began on December 1, 2002. Susan and I went to church and then to the Waffle House for breakfast with our sons Cullum and Pierce who were home from college for Thanksgiving. At breakfast, we talked with the boys about things they could do to be safe, knowing they would be leaving to return to school on the busiest travel day of the year. After breakfast, we went home and the boys loaded up their car and

started their drive from our home in Atlanta to their school in Virginia. They were within three miles of arriving there when they were stopped in traffic and were hit from behind by a speeding truck with the cruise control set at eight miles per hour over the posted speed limit. That evening, when Susan and I were waiting to get a call that the boys were safely back at school, we instead got the call from Pierce telling us that his big brother and hero had been killed.

Right after the crash, Pierce was too upset to speak with the state trooper in charge of the crash scene. Consequently, the trooper only spoke to the truck driver. He told the trooper that Cullum and Pierce's car had been in the right lane and, at the very last moment, pulled in front of the truck, causing the truck to hit their car. The truck driver reported that both vehicles then continued into the median of the highway, ending up between the road and the embankment in the median. Although there were many witnesses, the trooper did not interview any of them or record any of their names. Therefore, the resulting police accident report (PAR) reflected only the truck driver's false statements about how the crash happened.

Since Pierce miraculously survived the crash, the truth was quickly discovered. The boys' car had always been in the left lane and was stopped there. When Cullum looked in his rearview mirror and realized that a truck was bearing down on them fast, he had to make a split-second decision to flee or to stay where he was and take his chances. Cullum had done exactly what we had trained him to do; he had stopped with enough maneuvering room in front of him and looked in his rear-view mirror and then he chose to flee. He drove onto the median which is where the crash occurred, not in the left lane as the truck driver had stated. At the last second, the truck driver realized that he was not going to be able to stop and he drove the truck into the median, hitting one car, my son's car, instead of many.

Based on the truck driver's statement, the trooper in charge at the scene believed that if it had not been for Cullum's decision to pull into the left lane in front of the truck, there would have been no injuries that night, let alone a death. The trooper did recognize that the truck driver was driving too fast for the conditions and charged him with reckless driving. The state trooper, I'm sure was doing his best and, after hearing the truck driver's story, probably didn't see the need to interview other witnesses. My younger son Pierce, was too distraught to give a statement at the scene, and the trooper had other responsibilities to take care of at the crash scene. Yet, the bottom line is that the trooper took the truck driver's word about what happened, and this is the only version of the crash reflected in the PAR. However, in advance of the truck driver's trial, Susan and I had to hire a private investigator to find other eye witnesses, all of whom came forward and corroborated Pierce's version of the crash. As a result of this eyewitness testimony, the truck driver was convicted of reckless driving, but served only 30 days in jail for killing our son.

If we were limited only to the version of the crash recorded in the PAR, and Pierce had not survived, or if Susan and I lacked the means to pay for an additional investigation, the truth would not have been discovered or proven. We would have lived the rest of our lives not only with the loss of our son, but also with the devastating belief that he had caused his own demise by not being attentive on the road. Our family is haunted to think about how many parents, spouses, and loved ones of victims of truck crashes erroneously think just that and lack the knowledge or the financial resources to take the steps to find the truth.

Changes Being Considered to CSA Crash BASIC

The FMCSA is considering changing the way the CSA Crash BASIC handles crash data. Currently, all crashes, regardless of fault, are counted in the crash data. The FMCSA uses this data because past crash history is an accurate predictor of future crash involvement. The change being considered would classify crashes as "preventable," "non-preventable," and "undetermined," based solely on the PAR. Crashes deemed "non-preventable" would then be removed from the carrier's Crash BASIC score. These changes are not only unnecessary, but have the potential to compromise the data integrity short term when it is used for intervention and compliance, as well as when it is used in longer term studies. The Crash BASIC is working as intended to successfully identify high risk carriers for intervention, and the data should not be manipulated.

It is well established within the truck research community that crashes, in and of themselves and regardless of fault are effective predictors of future crashes. A 2005 American Transportation Research Institute (ATRI) study determined that a past truck crash increased the likelihood of a future crash by 87 percent (http://www.atri-online.org/research/results/One-Pager%20CMVE.pdf). Past crashes are indicative of future crash risk irrespective of a finding of "fault" or "preventability" in a particular crash and support FMCSA's process of including all crash data.

It is a tremendous mischaracterization to say that this process is unfair and that some trucking companies are being blamed for crashes that they did not cause. Fault is not, and never has been, a part of this process. FMCSA's materials and public display of crash data clearly state that the crash data is based on crash involvement without determination of responsibility (FMCSA Testimony, House Small Business Committee, July 11, 2012). The crash data is used solely as an analytical tool to identify motor carriers that can benefit prospectively from intervention by the agency. Additionally, with all companies being held to the same standard of inclusion, the playing field is level and fair.

Another critical issue with classifying crashes is that the determination would be based solely on information contained in the PAR. My own family's crash is but one of many examples of how PARs may lack complete and accurate information and cannot be used to determine truck

crash preventability. Indeed, PARs do not even include information on crash preventability. Moreover, missing and incomplete information on PARs is an unavoidable consequence of truck crashes in which 97 percent of the injuries and deaths are suffered by car passengers who cannot speak for themselves at the scene of the crash. A recent study conducted by the Illinois Department of Transportation found that more than 70 percent of crash reports filled out by Chicago Police Department officers were missing data and 30 percent had errors (http://articles.chicagotribune.com/2012-04-23/classified/ct-met-getting-around-0423-20120423_1_crash-reports-red-light-cameras-data). Our police officers do a tremendous job at the scene of crashes, but they are necessarily limited in their ability to investigate beyond basic information. Their extensive duties at a crash scene include: securing the scene; managing traffic to prevent further collisions; checking for injuries; providing basic care to the injured if necessary; and, identifying immediate hazards such as fires and summoning assistance as necessary (http://www.theiacp.org/LinkClick.aspx?fileticket=6LEWIkF%2BafU%3D&tabid=87). The information in a PAR is inadequate to answer questions of why or how a crash occurred above what is reported by the conscious and able survivors, and cannot provide a reliable basis for such a determination.

Should FMCSA pursue changes to classify crash data, in spite of issues with maintaining data integrity and PAR inadequacy, cost and inefficiency would quickly overwhelm the process. In order to proceed in a fair and comprehensive manner, FMCSA would need to undertake a massive investment in qualified personnel to first develop a system to determine preventability and then to staff and monitor a separate department to provide determinations of fault or preventability in a manner that would provide the public and the industry with sufficient confidence in accuracy and integrity of the system. A fair and thorough system would require that all pertinent crash information, including any subsequent crash investigation or accident reconstruction report, be included in the review, that only qualified and experienced crash reconstruction personnel evaluate the relevant information, and that parties involved in the crash be allowed to participate in the review and submit evidence and eyewitness and expert testimony. The failure to establish a fair and transparent procedure will doom the enterprise. Moreover, the FMCSA simply does not have the resources to properly develop and maintain a system which would require investigation, documentation, evaluation and the expertise necessary to prove fault and determine preventability in truck crashes. After all, that is the function of the criminal and civil courts and, again, fault assignment is not pertinent to predicting future crashes (the intent of the Crash BASIC) via CSA.

The FMCSA's resources are better spent expanding the CSA Program in ways to reach more carriers who could benefit from intervention - and current SMS data shows that there is room for improvement. The CSA Program is intervening with approximately 50,000 carriers who are involved in 45 percent of known crashes while it has data on 200,000 carriers who are involved

in 92 percent of known crashes (FMCSA presentation to MCSAC, August 2012). Expanding a working system to reach a greater percentage of carriers who are involved in crashes but have not crossed a threshold for intervention is a much better use of limited agency resources than creating an expensive, time consuming bureaucratic process with little possibility of producing a reliable result or an identifiable improvement.

CSA BASIC Thresholds for Intervention

The setting of thresholds for intervention, within the CSA BASIC categories, is an area that warrants examination to improve efficiency and increase effectiveness. For example, carriers are currently rated using a comparison or "benchmark" approach in each BASIC category. This type of approach allows acceptance of poor or mediocre safety performance, since a carrier is only measured against other carriers. If a large portion of carriers are performing poorly in a particular BASIC category, this allows a poorly performing carrier below the threshold to avoid intervention. The carrier is not performing well, and may not necessarily be safe, but it is just performing better than other poorly performing carriers. In other words, they are being graded on a curve. Since the tragic airline crash in Buffalo, NY on February 12, 2009, which caused the deaths of 50 people, more than 12,000 people's lives have been lost in large truck crashes. Rather than accepting an average and sometimes poor performance from carriers, our goal must be to aggressively reduce this devastating, high level of truck crash related fatalities and injuries.

This system could and should be improved by determining a safety rating reflective of safe practices and good performance and requiring carriers to achieve that rating in order to avoid intervention. It is likely that more carriers would then be targeted for intervention more quickly. Even when carriers have exceeded the threshold level for a BASIC, they will most likely only get a letter in the mail, with the assurance that no further action will be taken for 12 months unless they do something drastic that forces the agency to take real action. These carriers, that are performing badly enough to exceed the threshold, can then continue to operate for a year without making improvements before the agency will consider any additional action. The combined effect is that the agency is tolerating a situation in which tens of thousands of motor carriers are allowed to continue to operate at a persistently poor and substandard level of safety. Improvements within these areas are necessary as well as increasing transparency as to how the agency determines the threshold levels in each BASIC, and how and when the agency determines what type of intervention or enforcement action should be undertaken within those threshold levels.

Public Access to Information

Public access to CSA Program information, data, and improvements is essential to maintaining a fair and transparent process. The information and data FMCSA collects for its CSA Program comes through public agencies, regarding crashes that occur on public roads, paid for by tax-payer dollars and ultimately affecting public health and safety. FMCSA Administrator Anne Ferro has said, "CSA is raising the bar for truck and bus safety." This bar is being raised because bad actors within the industry are being held accountable in the public venue for their safety practices and rightly judged as unsafe when failing to meet standards. Perhaps the greatest influence is that the trucking industry and its safety record have a higher visibility. Doing business safely must be reinforced, especially considering that the trucking industry is adding approximately 75,000 new carriers each year (FMCSA Data). Public access to safety information is essential to attaining and perpetuating safe roadways.

Conclusion

FMCSA's CSA Program is a positive step in the right direction. It has already yielded significant improvements to truck safety and should not be changed in ways to diminish or dilute its effectiveness. We urge preservation of CSA's practice of including all crashes in its Crash BASIC because it is an efficient, highly effective predictor of future truck crashes. In addition, transparency, regarding the methodology and logic behind the threshold settings being employed is essential, as well as ensuring public access to safety rating information.

Unlike the Federal Aviation Administration (FAA) whose budget to promote safety within its industry is very large compared with the number of deaths and injuries that occur each year in plane crashes, the FMCSA's budget is extremely small and must be used with great purpose and efficiency to prevent as many of the tens of thousands of deaths and injuries caused by truck crashes every year as possible. The FMCSA should have resources commensurate with the size and scope of the industry it attempts to monitor and make safe. Unfortunately, while the FMCSA is responsible for an industry significantly larger than the aviation industry, it has only a fraction of the FAA's resources.

Thank you for the opportunity to testify this morning. Our organizations look forward to working with the Subcommittee and the full Committee Members to continue to make improvements to truck safety. We urge you to support the CSA advances that are changing the culture within some of the trucking industry to engender a competitive safety environment that benefits all drivers on our roadways.