PUBLIC TRANSPORTATION SAFETY BOARD
ABBREVIATED BUS ACCIDENT REPORT

1. CASE#: 9163
2. PROPERTY NAME: MTA Bus Co.
3a. ACCIDENT TYPE: Door Interlock
3b. Accident Severity Index: 0.50
4a. DATE: November 1, 2006
4b. TIME: 7:40 p.m.
5. ACCIDENT LOCATION: 45th Avenue at Parsons Boulevard
6. TOWN/CITY/BOROUGH: Flushing, NY
7. SUMMONS: No
8. BUS NUMBER: 9948
8a. YEAR: 1998
8b. MAKE: Orion V
9. NUMBER OF INJURIES: 1
10. FATALITIES: 0
11. HOURS OF SERVICE: 13 hr 1 min in last 24 hrs/52 hrs 59 min in last 7 days
12. SYNOPSIS:

At approximately 7:40 p.m., MTA Bus Company (MTABC) bus #9948 was standing in the bus stop on 45th Avenue at the intersection with Parsons Boulevard discharging passengers. When the bus driver determined that the last passenger had departed the bus he closed the front and rear doors and began to move the bus from the bus stop. As the bus began to move the bus driver heard a scream, immediately stopped and exited the bus to find that the rear doors had apparently not fully closed and a 9 year old female passenger had jumped from the bus and fell to the pavement. The female passenger claimed injury and was transported to a local hospital where she was admitted for a condition not related to the accident.

In the vicinity of the accident site 45th Avenue is a two-way east/west roadway accommodating one travel lane in each direction. Parking is permitted at both curbs. Parsons Boulevard is a two-way north/south roadway with one travel lane in each direction. Parking is permitted at both curbs. Both roadways are asphalt paved, straight, level and in good condition. At the time of the accident it was dark, the weather was clear and the pavement was dry. The area speed limit was 30 mph. The environment did not contribute to the accident.

Bus #9948 is a 1998 Orion V transit type bus housed and maintained at the College Point Depot with a seating capacity of 45 passengers. A review of the bus records showed that Preventive Maintenance Inspections are performed at regular 4,000 mile intervals, the most recent was completed on September 23, 2006 and the bus had traveled 2,557 miles since then. The records showed that on October 22nd and 24th, defects in the rear door interlock system had been identified and repaired [left side #1 (LS1) door close micro switch and interlock relay switch were replaced and adjusted]. The records also showed that on October 31st (day before the accident) a defect had been noted on the Driver Vehicle Inspection Report (DVIR) indicating that “bus can move with the rear door open”. There was no record that the defect had been repaired and the bus was allowed to return to service on November 1, 2006. A post accident inspection of bus #9948 was conducted on November 3, 2006 by the combined staffs of the Public Transportation Safety Board (PTSB), MTA NYCT Office of System Safety (OSS), MTA NYCT Technical Services and MTABC. Testing of the rear door interlock mechanism duplicated the condition claimed by the bus driver. Further inspection of the interlock mechanism found (from the Technical Services report) “a bent actuator tab on the rear door cam which allowed the LS1 micro switch to disengage prematurely”. This resulted in the bus being able to move only if the bus driver moved the door control handle from the interlock applied position and the rear doors were held open at the same time, such as when a passenger exits the bus.
No other defects were found which would be considered a causative factor in the accident. Prior to returning the bus to service decelerometer tests performed on the bus’ braking systems showed stopping distances that met the standards for passenger vehicles of NYS DOT Regulations (Title 17 of NYCRR, Article 3, Part 720).

The bus driver was hired by Queens Surface Corp. on May 13, 1996 and completed the New Bus Operator Training Program. A review of the driver’s Department of Motor Vehicles records for the past three years showed no violations, convictions or suspensions. NYS Vehicle & Traffic Law, Article 19-A records were reviewed and found to be complete, in order and up-to-date. A review of the driver’s MTABC accident record for the past three years showed three preventable collision accidents (03/02/04-warning, 07/18/05-re-evaluation and warning, 07/06/06-warning). Post accident drug and alcohol tests performed by MTABC on the bus driver upon his release from the accident scene, 2 hours and 50 minutes from the time of the accident, were negative.

In the bus driver’s post accident written report he made the following statements that:

- He closed the front doors and observed the rear doors closing. The light at the rear door and the front indicator light showed door closed.
- He stepped off the brake and the bus moved forward. He heard a scream, stopped and exited the bus.
- He observed a crying child by the rear doors. He repeatedly asked the parents if the child was okay to which they said she was.
- He re-boarded the bus and pulled up to the traffic light.
- He heard a knock at the front door and the child’s mother said she wanted the child looked at.

In a verbal interview the bus driver indicated that the girl’s father claimed that he grabbed the closing rear doors when he realized that the bus was beginning to move with his daughter still on the bottom step. The bus driver said that he was told that the little girl jumped from the moving bus and fell to the ground. The bus driver further indicated that prior to closing the doors he had checked outside and inside mirrors and did not see anyone in the rear stepwell.

Part of the MTABC training for servicing bus stops says that bus drivers are to insure that all boarding passengers are on and all exiting passengers are off the bus by checking all mirrors, interior and exterior, prior to closing the doors and moving the bus. Additionally, before moving from the bus stop all bus drivers are to check for intending passengers who may be running for the bus.

Public Transportation Safety Board staff finds that the probable cause of this accident was the failure of MTA Bus Company maintenance personnel to repair a defect that had been written up on the DVIR card dated October 31, 2006. Contributing to the accident was the failure of the bus driver to adhere to his training by not checking that everyone was clear of the bus in the mirrors prior to moving the bus.
At a hearing, the MTA Bus Company rated the accident preventable on the part of the bus driver, re-trained him, evaluated his driving skills and recommended that he be returned to passenger service. In addition, the bus driver was issued a written warning which was placed in his permanent record.

The MTA Bus Company was unable to identify exactly who failed to note the defect written up on the DVIR card. To insure that this did not happen again a procedure was developed where a designated foreman will, on a daily basis, review the DVIR cards and compare the results of the review with scheduled repair work.

Based on the actions taken by the MTA Bus Company regarding this accident, the Public Transportation Safety Board staff makes no recommendation in this case.

INVESTIGATORS: Harry W. Gerham

CHIEF, ACCIDENT INVESTIGATION SECTION

DIRECTOR, PCSB, NYSDOT