NATIONAL TRANSPORTATION SAFETY BOARD

An Independent Federal agency

Testimony of the Honorable Christopher A. Hart
Chairman
National Transportation Safety Board
Before the
Subcommittee on Transportation and Public Assets and
Subcommittee on Government Operations
Committee on Oversight and Government Reform
United States House of Representatives
on
A Safe Track?: Oversight of WMATA's Safety and Maintenance
Washington, DC
December 2, 2016

Good morning Chairman Mica, Chairman Meadows, Ranking Member Duckworth, Ranking Member Connolly, and the Members of the Subcommittees. Thank you for inviting the National Transportation Safety Board (NTSB) to testify before you today.

The NTSB is an independent federal agency charged by Congress with investigating every civil aviation accident and significant incidents in the United States and significant accidents and incidents in other modes of transportation—rail, highway, marine and pipeline. The NTSB determines the probable cause of accidents and other transportation events and issues safety recommendations aimed at preventing future accidents. In addition, the NTSB carries out special studies concerning transportation safety, and coordinates the resources of the federal government and other organizations assisting victims and their family members who are impacted by major transportation disasters.

Since its inception, the NTSB has investigated more than 400 railroad accidents, including rail transit accidents. On call 24 hours a day, 365 days a year, NTSB investigators travel throughout the country and internationally to investigate significant accidents and develop factual records and safety recommendations with one aim—to help ensure that such accidents never happen again.

History of Oversight of WMATA

In order to discuss the current safety oversight challenges regarding the Washington Metropolitan Area Transit Authority (WMATA), it is important to understand the statutory history that has led to the current state. The Intermodal Surface Transportation Efficiency Act of 1991 established the State Safety Oversight (SSO) program; this program went into effect in 1997. Under this program, states are responsible for the safety of the rail fixed guideway systems within their borders. Each state is required to establish a state safety oversight agency (SSOA) that sets requirements for rail transit safety and monitors the performance of rail transit agencies in accordance with those requirements.

Since the establishment of the SSO program, the NTSB has investigated serious accidents involving WMATA and has identified inadequate oversight and regulation as a persistent problem. In general, the NTSB investigations of WMATA have found that, although safety program plans were in place, they were not effectively implemented or overseen. State oversight challenges regarding WMATA are particularly acute because WMATA is the only transit property in the United States that involves three jurisdictions—Maryland, Virginia, and the District of Columbia. Most transit properties involve one jurisdiction and a few involve two, but WMATA is the only one with three. After the NTSB investigated the 2009 accident near the Fort Totten Station, discussed later in this testimony, we called for increased regulatory oversight of rail transit properties and recommended that the U.S. Department of Transportation (DOT) seek legislative authority to provide safety oversight.

On July 17, 2012, President Obama signed into law the Moving Ahead for Progress in the 21st Century Act (MAP-21).[1] MAP-21 made a number of fundamental changes to the statutes that authorize the federal transit programs. Under the law, the Federal Transit Administration (FTA)

[1] Pub. L. 112-141.

must certify oversight agencies, and, once certified, an SSOA can receive federal grant funds. To gain certification, an SSOA must show the FTA that it is financially independent of the rail transit system it oversees, has adequate authority to oversee those systems, and has adequate resources to hire appropriate staff.

To comply with the MAP-21 SSO program requirement, the FTA published the SSO Program final rule, which took effect on April 15, 2016.[2] Among other things, the SSO rule gave the FTA the authority to review and approve each state's SSO program and take enforcement actions against those states with nonexistent or noncompliant safety oversight programs. In addition, it required each state to establish an SSO program and ensure that the SSOA is financially and legally independent from any rail transit agency it oversees, and meets a number of requirements intended to assure that its oversight is effective. Each state with federally funded rail transit properties must have an SSO program approved by the FTA administrator by April 15, 2019.

In 2013, the FTA notified the Tri-State Oversight Committee (TOC), the SSOA for WMATA, that it did not meet MAP-21 certification requirements. The FTA's concerns with the TOC focused on the TOC's lack of effectiveness as a legal organizational model for overseeing WMATA. In response, Governor McAuliffe (Virginia), then Governor O'Malley (Maryland), and then Mayor Gray (District of Columbia) wrote to the Secretary of Transportation to authorize what they described as an actionable step to establish an independent SSOA that would conform to MAP-21. In doing so, they proposed the Metro Safety Commission (MSC), an independent organization that would assume the responsibilities of the TOC. The letter offered no detail, but it referenced a White Paper, *Optimizing State Safety Oversight of the WMATA Metrorail System*, prepared by the three jurisdictions. The White Paper described the three jurisdictions' collective ideal SSO program for the oversight of WMATA and proposed actions necessary to achieve that ideal. However, it included no details about establishing legal authority in a way that overcomes the multijurisdictional problems faced by the current TOC. Finally, the authors admitted other challenges, such as resources; legislation at the local, state, and federal levels; and budgetary constraints of all three jurisdictions that may further limit progress in achieving an effective safety oversight program.

Maryland, Virginia, and the District of Columbia entered into a memorandum of understanding on February 25, 2016, which restated their commitment to establishing the MSC. However, legislation in all three jurisdictions is still needed to do so and Maryland and Virginia have formally notified DOT that they will not meet the February 9, 2017 deadline to establish a new SSOA, risking the withholding of $15 million in federal funds through the Urbanized Area Formula Funding ("Section 5307") program from public transportation systems in the three jurisdictions.[3] The NTSB remains concerned that Maryland, Virginia, and the District of Columbia will continue to encounter legislative impediments that will further delay the establishment of the MSC or other SSOA that would be able to effectively oversee the safety of WMATA.

Based on 45 years of inadequate safety oversight of the WMATA Metrorail system, the NTSB has concluded that neither the regulatory changes the FTA can make as a result of MAP-21 nor the proposed creation of the MSC would likely resolve the deficiencies identified in safety

[2] 81 FR 14230 (March 16, 2016); codified at 49 C.F.R. Part 674.

[3] Martine Powers "Md. and Va. won't meet deadline for new Metro safety body. What happens now?" *The Washington Post*, November 26, 2016.

oversight of WMATA in a timely manner. Therefore, as a result of the investigation into the WMATA Metrorail smoke and arcing accident near L'Enfant Plaza Station on January 12, 2015, the NTSB issued urgent safety recommendations to the Secretary of Transportation on September 30, 2015. The NTSB makes urgent recommendations to address circumstances that create an imminent danger to the public. In this case, the NTSB recommended that the DOT seek an amendment to 45 U.S.C. § 1104(3) to list WMATA as a commuter authority, thus authorizing the Federal Railroad Administration (FRA) to exercise regulatory oversight of WMATA. The NTSB also recommended that the DOT direct the FRA administrator to develop and implement a plan to transition the oversight of WMATA to the FRA within six months.[4] The NTSB recommended the change in oversight because the FRA has robust regulatory and enforcement powers, allowing it to more quickly and more effectively address hazards and improve the overall safety of WMATA's rail operations.

Investigations of WMATA Metrorail Accidents and Incidents

East Falls Church Derailment

Since 1982, the NTSB has investigated 14 accidents involving WMATA. Most recently, the NTSB has been investigating the July 29, 2016 derailment of Metrorail train 602 near Falls Church, Virginia. Metrorail train 602 derailed while traversing a crossover (that enables a train to transition from one track to a parallel track) in the East Falls Church interlocking, operating on the Silver Line. About 63 passengers were on board the six-car passenger train, all of whom were evacuated out of the lead car, assisted by the Metro Transit Police Department. Three passengers reported injuries, including one who was hospitalized.

The NTSB dispatched two investigators to the scene of the derailment to assess the accident and to determine if a broader investigation was necessary. Our investigators noted that the track gage measurement (distance between the two rails) near the point of derailment was nearly 2 inches wider than acceptable by WMATA standards. The design track gage is 56-1/4 to 56-1/2 inches. In track of similar construction to the accident area, WMATA requires that track gage in excess of 57-1/4 inches be removed from service, and train movement on the track is prohibited until the defect is corrected. Near the point of derailment, however, track gage measured 59 inches, yet the track remained in service.

The presence of deteriorated wooden crossties near the point of derailment caused the track gage to exceed the maximum WMATA standards. In the derailment area, the rail was fastened through tie plates to standard wooden crossties. NTSB investigators identified many defective crossties in the area of the derailment. WMATA track standards require there be no more than 120 inches between nondefective fasteners for tracks of similar construction; however, in this accident area, investigators noted over 400 inches of track with no effective rail fasteners because of deteriorated crossties.

WMATA has standards that address defective crossties; however, it was not apparent that the track structure in the accident area was consistently maintained to those standards. The FTA does not prescribe minimum track safety standards. The FTA's lack of minimum track standards is

[4] R-15-031 and -032.

but one example of the need for the Secretary of Transportation to take immediate action to implement the NTSB's September 2015 urgent safety recommendation to transition the federal oversight of WMATA from the FTA to the FRA. Unlike the FTA, FRA's regulations contain safety standards.

The WMATA *Track Maintenance and Inspection Manual* requires "no fewer than seven nondefective rail fasteners within 40 feet," and requires that track with more than 120 inches between nondefective ties be removed from service. In a distance of 40 feet of track structure near the point of derailment, there were 18 crossties. Of those, 16 were not in compliance with WMATA standards or FRA track safety standards, resulting in about 400 inches of unsupported rail. The deteriorated crosstie condition allowed for a total track gage measurement of 59 inches. When track gage is too wide, the proper wheel-rail interface cannot be maintained and derailment is likely, as was the case in East Falls Church.

This week, the NTSB issued an accident brief setting forth the findings of our limited investigation of the East Falls Church derailment.[5] We determined that the probable cause of the accident was a wide track gage condition resulting from the sustained use of deteriorating wooden crossties due to WMATA's ineffective inspection and maintenance practices and inadequate safety oversight.

On August 6, 2015, a similar accident occurred on the WMATA system. A nonrevenue employee train, WMATA Metrorail train 412, derailed on approach to the Smithsonian interlocking. Three of the six cars derailed; none of the derailed cars had reached the switch points of the interlocking. WMATA's investigation into the derailment revealed that on July 9, 2015, a WMATA track geometry vehicle inspected track measurements through the area where the train derailed. This inspection revealed a gage measurement of 58-1/16 inches at the area where train 412 derailed less than 1 month later. This gage exceeded WMATA's maximum gage standard. WMATA guidelines required immediately removing the track from service, based on the wide gage measurement, until repairs are completed. WMATA, however, continued to run revenue service trains over the track, with no reduction in speed or other mitigation action, for the 27 days between the discovery of the gage defect and the derailment on August 6, 2015.

The *WMATA Track Maintenance and Inspection Manual* also provides instruction for track maintenance and inspection procedures on the WMATA system. According to the manual, all main tracks and secondary tracks will be examined on foot by qualified track personnel twice each week with an interval of a least 1 calendar day between inspections. NTSB investigators reviewed transcripts of interviews with WMATA track inspectors and track supervisors and learned that WMATA only inspected some crossover switches, such as the one involved in the East Falls Church derailment, on a monthly basis, instead of twice-weekly as required. FRA regulations not only contain the same twice-weekly track inspection requirement, FRA inspectors routinely review track inspection records for compliance with FRA regulations and railroad rules and procedures. The FTA has no such regulations in place.

[5] National Transportation Safety Board, *Derailment of WMATA Metrorail Train in Interlocking, Falls Church, Virginia,* RAB-16-06 (Washington, DC: National Transportation Safety Board, 2016).

NTSB investigators reviewed WMATA's monthly switch inspection reports from January 2015 to July 2016. Investigators noted that all of the inspection reports for the crossover involved in the East Falls Church derailment documented a defective condition of "15 deteriorating ties…." NTSB investigators learned that the defective track conditions that led to the East Falls Church derailment had been previously identified by WMATA inspectors, yet were not properly remediated. Based on this documentation, NTSB investigators requested additional documents showing all reported defective track conditions that were awaiting approval. WMATA provided a report that showed a total of 16,828 open track defects, some going back to October 2008, that were still waiting to be repaired.

The recent East Falls church derailment caused by substandard track is another example of why immediate action is required to address safety issues at WMATA. FRA track safety standards are part of a more established inspection, oversight, and enforcement program, and the NTSB remains convinced that with the history of accidents at WMATA, the FRA's mature regulatory program is vital to increasing passenger safety.

L'Enfant Plaza Station Electrical Arcing and Smoke Accident

On January 12, 2015, WMATA train 302 stopped after encountering heavy smoke while traveling southbound in a tunnel between the L'Enfant Plaza Station and the Potomac River Bridge in Washington, DC. About 380 passengers were aboard the six-car passenger train at the time of the accident. Some passengers self-evacuated from the train, while emergency responders assisted others. The smoke originated from an electrical arcing event near the third rail about 1,900 feet south of the L'Enfant Plaza Station. Smoke filled the L'Enfant Plaza Station, which was evacuated. The train was stopped at 3:15 p.m. and all passengers were evacuated to safety by 4:27 p.m. As a result of the accident, one passenger died and 91 people were injured—including passengers, emergency responders, and WMATA employees.

To gather additional factual information in support of the NTSB's L'Enfant Plaza Station accident investigation, we convened a two-day investigative hearing in June 2015. The hearing examined four broad issue areas: the state of WMATA's infrastructure, emergency response efforts, WMATA's organizational culture, and the FTA's and the TOC's efforts to address public transportation safety. Witnesses from various parties involved provided important first-hand insight on what happened and addressed larger questions raised by the accident. Additionally, the NTSB brought in representatives from Montgomery County Fire and Rescue Services, Metro-North Railroad, and the United Kingdom's Office of Rail Regulation to share their relevant experience in preventing and responding to accidents.

On March 14, 2016, WMATA informed the NTSB of an arcing event early that morning at the McPherson Square Station in downtown Washington, D.C. The NTSB was invited to view some of the damaged electrical components. NTSB staff observed surveillance video of the McPherson Square Station platform, photographs of the incident location, and components that had been removed from the incident location. We observed that the damage to the third rail electrical components was similar to that of the L'Enfant Plaza Station accident. One cable connector assembly and portions of the cables, as well as a portion of the third rail cover board, had been vaporized. Surveillance video showing smoke filling the McPherson Square Station was also similar

to what occurred on the L'Enfant Plaza Station platform. However, it is not clear what caused the arcing event at the McPherson Square Station.

On May 3, 2016, the NTSB adopted the final accident report regarding the arcing and smoke accident near L'Enfant Plaza and determined that the probable cause of the accident was a prolonged short circuit that resulted from WMATA's ineffective inspection and maintenance practices.[6] The ineffective practices persisted as the result of (1) the failure of WMATA senior management to proactively assess and mitigate foreseeable safety risks, and (2) the inadequate safety oversight by the TOC and the FTA. Contributing to the accident were WMATA's failure to follow established procedures and the District of Columbia Fire and Emergency Medical Services Department's lack of preparedness to respond to a mass casualty event on the WMATA underground system.

The report cited safety vulnerabilities throughout the WMATA system, including infrastructure maintenance, tunnel ventilation, railcar ventilation, responses to reports of smoke, and management deficiencies. Our findings also illustrated WMATA's continued inability to apply the information gained since 1982 through accidents previously investigated by the NTSB, eight of which involved fatalities. WMATA failed to learn safety lessons from the NTSB's prior studies and accident investigation reports.

As a result of its investigation of the L'Enfant Plaza accident, the NTSB issued 31 new safety recommendations, including 24 to WMATA, 2 to the FTA, 1 to the mayor of the District of Columbia, 3 to the District of Columbia Office of Unified Communications, and 1 to the District of Columbia Fire and Emergency Medical Services Department. These safety recommendations supplemented the urgent safety recommendations we issued in the immediate aftermath of the accident concerning FRA oversight.

The 24 new safety recommendations to WMATA encompassed a broad range of measures including: review and revise WMATA tunnel inspection, maintenance, and repair procedures to mitigate water intrusion into tunnels; improve the capacity of tunnel ventilation fans to conform to the requirements of National Fire Protection Association Standard 130; develop location-specific emergency ventilation configurations based on engineering studies; develop and implement procedures for actions to be taken by Rail Operations Control Center personnel when smoke detectors alarm; develop procedures for regular testing of all smoke detectors; and others.[7] WMATA provided an initial response on August 18, 2016 indicating its progress toward implementing many of the recommendations.

In addition, the NTSB recommended that the FTA issue regulatory standards for tunnel infrastructure inspection, maintenance, and repair, incorporating applicable industry consensus standards into those standards; and that the FTA issue regulatory safety standards for emergency

---

[6] National Transportation Safety Board *Washington Metropolitan Area Transit Authority L'Enfant Plaza Station Electrical Arcing and Smoke Accident, Washington, D.C. on January 12, 2015*, RAR-16-01 (Washington, DC: National Transportation Safety Board, 2016).

[7] R-16-008 through -031, May 23, 2016.

egress from tunnels.[8] On May 17, 2016, the FTA published a Federal Register notice soliciting public comment on the FTA's compendium of transit safety standards and protocols.[9] The FTA stated its intent to publish findings, including recommendations to revise applicable existing standards, and to issue new standards as needed. The NTSB has classified the new safety recommendations to FTA as "Open—Acceptable Response" pending our review of the FTA's revisions to existing standards and the creation of new standards where needed.

Other Significant WMATA Metrorail Accident Investigations

Of the 14 accidents involving WMATA that the NTSB has investigated since 1982, more than half occurred between 2006-2014. In addition, since 1970, the NTSB has issued 101 safety recommendations to WMATA.

The deadliest accident occurred on June 22, 2009, on aboveground track on the Metrorail Red Line near the Fort Totten Station in Washington, D.C. The lead car of train 112 struck the rear car of train 214. This resulted in a loss of occupant survival space in the lead car of train 112 of about 63 feet (about 84 percent of its total length). Nine people aboard train 112, including the train operator, were killed. Emergency response agencies reported transporting 52 people to local hospitals.[10] The NTSB determined that the ineffective safety oversight by the WMATA Board of Directors, the TOC's ineffective oversight and lack of safety oversight authority, and the FTA's lack of statutory authority to provide federal safety oversight were contributing factors in the accident. As a result of this investigation, the NTSB issued 16 safety recommendations to WMATA.[11]

Other significant WMATA Metrorail accidents investigated by the NTSB include:

- **November 29, 2009:** Rear-end collision of two Metrorail trains at the West Falls Church, VA, rail yard, resulting in injuries to three Metrorail employees and an estimated $9 million in damage to train equipment.[12]
- **January 7, 2007:** Derailment of a Metrorail train near the Mt. Vernon Square Station, Washington, DC, resulting in 23 passengers being transported to hospitals and an estimated $3.8 million in property damages.[13]

[8] R-16-001 and -002, May 23, 2016.

[9] 81 FR 30605 (May 17, 2016).

[10] National Transportation Safety Board *Collision of Two Washington Metropolitan Area Transit Authority Metrorail Trains Near Fort Totten Station, Washington, D.C. on June 22, 2009*, RAR-10-02 (Washington, DC: National Transportation Safety Board, 2010).

[11] R-10-007 through -022, August 10, 2007.

[12] National Transportation Safety Board, *Washington Metropolitan Area Transit Authority Rear-end Collision*, RAB-12/04 (Washington, DC: National Transportation Safety Board, 2012).

[13] National Transportation Safety Board, *Derailment of Washington Metropolitan Area Transit Authority Train near the Mt. Vernon Square Station, Washington, D.C. on January 7, 2007*, RAR-07-03 (Washington, DC: National Transportation Board, 2007).

- **November 3, 2004:** Collision of two Metrorail trains at the Woodley Park Zoo-Adams Morgan Station, Washington, DC, resulting in about 20 persons being transported to hospitals for treatment and an estimated $3.5 million in property damage.[14]
- **January 13, 1982:** Derailment of a Metrorail train at Smithsonian Interlocking, Washington, DC, resulting in three fatalities, 25 injured people, and an estimated $1.3 million in property damage.[15]

While some progress has been made on the safety recommendations stemming from the Fort Totten and earlier investigations, the L'Enfant Plaza Station accident, the electrical arcing incidents at the Court House and McPherson Square Stations, and the recent East Falls Church derailment show that more needs to be done.

NTSB Urgent Recommendations to WMATA and FTA After the L'Enfant Plaza Accident

Soon after initiating the investigation into the L'Enfant Plaza Station accident, the NTSB identified concerns with the ventilation systems that required immediate action. On February 11, 2015, we made three urgent safety recommendations to WMATA.[16] These urgent recommendations called on WMATA to: (1) assess the subway tunnel ventilation system, verifying that it is in good repair; (2) develop and implement detailed written ventilation procedures for its operation control center; and (3) base these procedures on the most effective strategy for fan direction and activation to limit passengers' exposure to smoke. In addition, we urged WMATA to incorporate these procedures into its ongoing training and exercise programs.

In response to the urgent safety recommendations, WMATA has informed the NTSB that it has completed the following actions: conducted a field assessment of the Metrorail system's Vane Axial ventilation fans and verified that they have no deficiencies, are operable, and are in a state of good repair; procured the services of a technical services firm to update WMATA's emergency standard operating procedures for fire and life safety processes in tunnels and underground stations and to develop a formal report for NTSB review; and is drafting an employee training program to implement the updated procedures. Therefore, we have reclassified the urgent safety recommendation concerning the subway tunnel ventilation system as "Closed—Acceptable Action" and the remaining urgent recommendations as "Open—Acceptable Response."

In a companion urgent safety recommendation issued on February 11, 2015, we also urged the FTA to audit all rail transit properties with underground rail operations to assess their ventilation

---

[14] National Transportation Safety Board, *Collision Between Two Washington Metropolitan Area Transit Authority Trains at the Woodley Park-Zoo/Adams Morgan Station in Washington, D.C. on November 3, 2004*, RAR- 06-01 (Washington, DC: National Transportation Safety Board, 2006).

[15] National Transportation Safety Board, *Derailment of Washington Metropolitan Area Transit Authority Train No. 410 at Smithsonian Interlocking on January 13, 1982*, RAR-82-6 (Washington, DC: National Transportation Safety Board, 1982).

[16] R-15-008 through -010, February 11, 2015.

systems.[17] In response to this recommendation, the FTA directed all SSOAs with jurisdiction over the 25 rail transit agencies with subway tunnels to conduct audits to assess and inspect tunnel ventilation systems and related issues. We have also classified this urgent safety recommendation as "Open—Acceptable Response."

The NTSB issued an additional safety recommendation to WMATA on June 8, 2015, addressing problems with the electrical connections in the Metrorail system.[18] The NTSB asked WMATA to inspect the cable connector assemblies and ensure that they are in accordance with WMATA's specifications, which includes the sealing sleeves. WMATA has reported that as of June 30, 2016, 71% of the 8,347 total power cable connector assemblies have been retrofitted. The NTSB is aware that this is a major undertaking, and that the work is being conducted during midday, night, and weekend hours. We will continue to closely monitor WMATA's progress in implementing this recommendation, which has been reclassified as "Open—Acceptable Response."

Status of NTSB Urgent Recommendations to DOT Concerning WMATA Oversight

The Secretary of Transportation responded to the NTSB's urgent safety recommendations regarding the change in WMATA oversight from FTA to FRA on October 9, 2015, acknowledging that the TOC lacked sufficient resources, technical capacity, and enforcement authority to provide the level of oversight needed to ensure safety at WMATA. However, the Secretary disagreed with the NTSB recommendation to transfer safety oversight of the WMATA rail system to the FRA, citing the enhanced authority of the SSOAs and the authority in MAP-21 for the FTA to assume the safety oversight in the absence of an effective SSOA. In a letter to the NTSB dated May 3, 2016, the Secretary further described FTA's oversight of WMATA.

The NTSB remains concerned that, while the Secretary of Transportation tasked the FTA with assuming the authority of the SSOA, the FTA has very limited ability to oversee WMATA effectively. Having only acquired safety oversight authority and responsibility in 2012, from MAP-21, the FTA has no prior experience in direct safety oversight or as an SSOA, has limited staff to carry out the function, has no regulations against which to measure compliance, and does not have the authority to levy civil or individual penalties in response to safety deficiencies. The NTSB understands that legislation enabling the creation of a fully functional SSOA for WMATA may be a lengthy process, and the FTA's temporary SSOA authority will likely exist longer than anticipated. Thus, the urgent safety recommendations remain classified "Open—Unacceptable Response."

The NTSB is not alone in its concern about the ability of the FTA to conduct oversight activities effectively. On November 2, 2016, the DOT Office of the Inspector General issued its audit report of the FTA's safety oversight program and assumption of WMATA rail safety oversight.[19] The report concluded:

---

[17] R-15-007.

[18] R-15-025.

[19] DOT Office of Inspector General, *Audit Report: Improvements in FTA's Safety Oversight Policies and Procedures Could Strengthen Program Implementation and Address Persistent Challenges* (Washington, DC: DOT Office of Inspector General, 2016).

> While rail transit is relatively safe, catastrophic incidents, such as the January 2015 WMATA incident, raise significant concerns about the effectiveness of rail transit safety oversight. FTA has taken steps to begin developing policies and procedures to assume and relinquish direct safety oversight, but lacks firm milestones for completion. Moreover, slow progress in implementing a data-driven, risk-based oversight system; limited safety performance criteria; and unenforceable safety standards further hinder the Agency's ability to provide proactive safety oversight. Unless FTA addresses these challenges, it may be unable to meet the Federal transit safety goals and objectives that are central to its enhanced safety oversight authority.

Although the Fixing America's Surface Transportation Act,[20] enacted in 2015, granted additional authority to the FTA, including the authority to exercise direct safety oversight of rail transit agencies when necessary to correct safety deficiencies and withhold not more than 25 percent of the Section 5307 program funds from recipients for noncompliance with safety regulations, we do not believe that these additional authorities address the concerns that we highlighted in our urgent safety recommendations. There are many uncertainties associated with the proposed the FTA approach to WMATA oversight. DOT implementation of our urgent safety recommendations that WMATA be ruled a commuter authority and that the FRA assume oversight responsibility for WMATA rail transit would eliminate these uncertainties much sooner because the FRA is an experienced regulatory safety oversight agency. The NTSB believes that the FRA is best positioned to oversee WMATA Metrorail, but the DOT, nevertheless, continues to move forward with FTA oversight. The NTSB will monitor the efficacy of this decision and continue to champion consistently strong oversight for all rail transit agencies.

Conclusion

The NTSB's annual Most Wanted List highlights safety-critical actions that the DOT, other federal entities, states, and organizations need to take to help prevent accidents and save lives. On November 14, 2016, the NTSB announced its Most Wanted List of transportation safety improvements for 2017-2018. The NTSB's investigation of accidents involving WMATA continue to illustrate that rail transit accidents cause injuries and deaths, and yet oversight of rail transit is unreliable in some cases, increasing safety risks. An effective, independent oversight system must be created to ensure that the highest possible level of safety is afforded to the American public. Therefore, the NTSB has carried-over "Improve Rail Transit Safety Oversight" from the 2016 to the 2017-2018 Most Wanted List.[21]

Thank you for the opportunity to testify before you today. I look forward to responding to your questions.

[20] Pub. L. 114-94.

[21] National Transportation Safety Board, *2017-2018 Most Wanted List*: Improve Rail Transit Safety Oversight.