Before the Commerce, Science, and Transportation Committee
Subcommittee on Consumer Protection, Product Safety, and Insurance
United States Senate

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NHTSA’s Oversight of
Vehicle Safety Defects and
Highway Safety Grants

Statement of
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Chairman McCaskill, Ranking Member Heller, and Members of the Subcommittee:

Thank you for inviting me to testify on our recent and ongoing work on the National Highway Traffic Safety Administration’s (NHTSA) oversight of vehicle safety defects and highway safety grants. NHTSA administers highway safety and consumer programs intended to save lives, prevent injuries, and reduce economic costs resulting from motor vehicle crashes. In 2012, motor vehicle fatalities in the United States totaled 33,561. To carry out its broad safety mission, NHTSA has a wide variety of responsibilities—ranging from overseeing the automobile industry’s efforts to manufacture cars that are free of defects to providing and overseeing grants to States and localities that fund initiatives to mitigate safety risks on the Nation’s highways.

My testimony today will focus on NHTSA’s efforts to identify and secure an effective defects workforce to oversee automobile safety and enhance its oversight of highway safety grants.

IN SUMMARY

- NHTSA’s Office of Defects Investigation (ODI) has made progress in strengthening its investigative processes but has not completed a workforce assessment.

- Ongoing vehicle safety concerns—particularly those related to General Motors’ (GM) recalls—prompt further assessment of NHTSA’s vehicle safety defect processes.

- Enhanced monitoring tools are needed to improve NHTSA’s oversight of highway safety grants.

BACKGROUND

The National Traffic and Motor Vehicle Safety Act authorizes NHTSA to issue vehicle safety standards and to require manufacturers to recall vehicles and equipment that have safety-related defects or that do not meet Federal safety standards. ODI conducts tests, inspections, and investigations to identify safety defects in motor vehicles and equipment. Based on its findings, NHTSA can require manufacturer recalls notifying the public and correcting the defects. When conducting investigations, ODI can request that manufacturers provide data on complaints, injuries, warranty claims, modifications, parts sales, and other items.

In 2011, we reported weaknesses in NHTSA’s vehicle defect identification processes. Specifically, ODI needed to improve its processes for (1) recommending investigations of potential defects, (2) determining when to use third-party assistance, (3) documenting investigation information, and (4) ensuring an adequate and well-trained workforce. In response to our recommendations, NHTSA has implemented more robust defect
investigation processes such as developing a framework for obtaining third-party testing and preparing a checklist to enhance documentation of investigative evidence.

The Moving Ahead for Progress in the 21st Century Act (MAP-21) authorized about $1.3 billion to fund highway safety formula and incentive grants for fiscal years 2013 and 2014. States distribute these grants to a wide network of sub-grantees nationwide. NHTSA’s regional offices monitor States’ and sub-grantees’ use of grant funds, such as conducting triennial management reviews and ongoing oversight.

**ODI HAS MADE PROGRESS IN STRENGTHENING ITS INVESTIGATIVE PROCESSES BUT HAS NOT COMPLETED A WORKFORCE ASSESSMENT**

As we reported in 2011 and testified before this committee in April 2014, ODI lacked the processes needed to ensure that manufacturers recall vehicles and equipment with safety-related defects in a timely manner.¹ Notably, ODI’s central database for safety defect information did not track the disposition of consumer complaints. These complaints are ODI’s primary means for determining whether an investigation is warranted. We identified similar weakness in ODI’s processes for determining when to use third-party assistance, documenting investigation information, and assessing workforce needs.

ODI has addressed 9 of our 10 recommendations for enhancing these processes (see attachment). However, it has not completed a systematic workforce assessment, as called for in the Department of Transportation’s (DOT) “Workforce Planning Guide.”² As we reported, conducting a comprehensive workforce assessment would enable ODI to determine the number of staff and specialized skills needed to ensure manufacturers recall vehicles and equipment with safety-related defects in a timely manner.

Since 2011, ODI has taken some action to analyze its workforce needs including preparing a statement of work, identifying a contractor, and obtaining a draft assessment. However, ODI staff recently told us that the final workforce assessment will not be available until November 14, 2014.

**ONGOING VEHICLE SAFETY CONCERNS PROMPT FURTHER ASSESSMENTS OF ODI’S PROCESSES**

Despite NHTSA’s progress in improving its processes for identifying vehicle safety defects, concerns remain—particularly in light of the recent GM recalls. Since February 2014, GM has recalled 8.6 million vehicles sold in the United States related to a

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² DOT’s “Workforce Planning Guide” provides information on assessing staffing needs for DOT Operating Administrations that can facilitate more efficient and accurate alignment of the workforce to meet organizational goals, commitments, and priorities.
possible defective ignition switch that can cause the engine to shut down and disable power steering, power brakes, and airbags. Initially, GM’s recall was limited to about 600,000 vehicles manufactured between 2005 and 2007, but eventually expanded to a total of four separate recalls impacting vehicles manufactured between 1997 and 2014.

In March 2014, the Secretary of Transportation asked us to undertake a review of NHTSA’s safety functions and processes related to the GM recalls. Expanding on our prior work, we are drilling down on NHTSA’s pre-investigation process. During the pre-investigation phase, ODI’s Defect Assessment Division screens consumer complaints, external manufacturer communications, and other information related to alleged safety defects (see figure). The information helps ODI determine whether to take actions, such as opening investigations or evaluating the adequacy of safety recalls.

**Figure. ODI’s Pre-Investigation, Investigation, and Post-Investigation Processes**

A critical part of the pre-investigation phase involves manufacturers’ early warning reporting to alert the Defect Assessment Division of potential risks or issues. As the Inspector General testified in April 2014, NHTSA cannot do its job effectively if auto manufacturers withhold critical safety information—as we found to be the case with the Toyota Motor Company. Upon showing that a manufacturer withheld such information, NHTSA, the Department, and in appropriate circumstances, our law enforcement and

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3 Toyota admitted that it concealed and made deceptive statements about safety issues affecting its vehicles, misleading U.S. consumers and NHTSA. Toyota was charged with wire fraud for providing the misleading information and forfeited $1.2 billion.
Federal prosecutorial partners can seek sanctions against these companies for withholding such information. In May 2014, NHTSA assessed a $35 million civil penalty—the statutory limit—against GM for failing to report the defective ignition switch in a timely manner.

As part of our ongoing audit, we are determining if information on ignition switch issues or non-deploying airbags was available to NHTSA but not used in the GM defect analysis. We plan to issue our final report next spring.

**ENHANCED MONITORING TOOLS ARE NEEDED TO IMPROVE NHTSA’S OVERSIGHT OF HIGHWAY SAFETY GRANTS**

In addition to identifying and addressing vehicle safety defects, NHTSA promotes vehicle safety through administration and oversight of highway safety grants to States and sub-recipients. In August 2014, we reported that NHTSA grantees generally met key Federal grant requirements, but NHTSA lacks strategies for addressing delayed expenditures of grant funds, tracking mechanisms for following up on grantee deficiencies, or tools to identify and mitigate systemic nationwide issues.

We focused on NHTSA’s Region 5 office, which we randomly selected from NHTSA’s 10 regional offices. Where appropriate, we identified vulnerabilities that applied across the Agency, including a lack of guidance and monitoring mechanisms.

NHTSA grantees we reviewed generally met key Federal grant requirements. Our sample review of 66 grant expenditures (totaling $5.7 million) by Region 5 States and their sub-grantees for fiscal years 2011 to 2012 did not identify significant lapses in the Region’s oversight. Our review of Region 5 grantees determined that each transaction (1) met funding parameters of the grant programs, (2) were charged to appropriate grant funding codes, and (3) were supported by sufficient documentation. For example, we verified two fiscal year 2012 expenditures by Indiana University’s Automotive Safety Program for $130,996 and $98,950. These two expenditures were made under an $850,000 occupant protection program grant agreement, which provided funds for child passenger safety programs. We also confirmed that States met Federal grant administrative requirements. For example, we verified that grantees complied with requirements for indirect costs, such as rent and motor pools, which were charged to Federal grants.

However, NHTSA lacks an overall strategy for addressing persistent delays in grantees’ use of grant funds—a shortcoming that affects all regional offices. For fiscal years 2006 through 2012, we identified approximately $539 million in unexpended funds across all

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4 As part of our review, we are also determining whether NHTSA has effectively implemented its enhanced processes for identifying and addressing vehicle safety defects.


6 Region 5 includes Indiana, Illinois, Michigan, Minnesota, Ohio, and Wisconsin.
regional offices. For Region 5 alone, the amount of unexpended funds was nearly $67 million (or about 12 percent of the national total). Unused safety grant funds represent potential lost or delayed opportunities to fund programs that reduce fatalities, injuries, and property damage. Although Region 5 has taken some action to encourage States to liquidate these balances, NHTSA has not developed sufficient strategies to better ensure that States use grant funds in a timely manner—such as developing individual funding liquidation plans for each State with specific targets and mitigation strategies.

In addition, NHTSA does not sufficiently track grantee deficiencies identified in its triennial management reviews of grantees. From fiscal years 2010 through 2012, NHTSA’s Region 5 officials conducted congressionally mandated triennial management reviews of all six of its State grant programs. These reviews identified deficiencies, such as improper use of funds and a lack of monitoring plans. However, some findings and recommendations were closed without sufficient documentation. Weaknesses ranged from NHTSA not maintaining documentation to States not providing sufficient documentation to support closing a recommendation. For example, Region 5 officials closed 7 of 9 findings and 16 of 25 non-binding recommendations made in the triennial management reviews but could not provide sufficient documentation of States’ actions to justify closing three of the findings and recommendations. Region 5 also lacked documentation of management’s approval for closing recommendations. NHTSA’s guidance and procedures, which apply to all regional offices, do not require documentation and management approval for key actions related to the disposition of grantee deficiencies. In our view, improved documentation would provide greater assurance that States are fixing identified issues.

Finally, NHTSA lacks a standardized mechanism for tracking the disposition of grantee deficiencies across all regional offices, which would allow the Agency to identify and mitigate systemic issues on a national level. In 2008, we recommended that NHTSA implement an electronic tracking system for monitoring the disposition of oversight recommendations to States in order to efficiently share findings, follow up on unresolved recommendations, and enhance quality control. In response to our recommendation, NHTSA agreed to implement a spreadsheet tool to track the deficiencies agencywide. However, during our recently completed audit, we identified weaknesses in NHTSA’s implementation of the spreadsheet. Notably, the spreadsheet is not directly linked to regional offices for real-time updates, and it lacks features to uniformly identify, classify, compare, track, mitigate, and report on systemic or recurrent grantee deficiencies. NHTSA committed to addressing these weaknesses by developing a database in 2015 that will allow users to track NHTSA’s findings until resolution; conduct queries and analyses to determine State, regional, and national trends; and produce management reports.

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NHTSA generally concurred with the four recommendations in our August 2014 report to improve its stewardship and oversight of Federal grant funds. We will continue to monitor NHTSA’s implementation of our recommendations as needed to ensure that NHTSA improves its grant guidance and monitoring tools for greater assurance that States and sub-grantees are using Federal resources in a timely and appropriate manner.

Overall, NHTSA has made progress in strengthening its defect investigation processes and ensuring that its grantees meet key Federal grant requirements. However, successfully implementing its enhanced processes, completing the workforce assessment, identifying and securing an adequate workforce, and enhancing grant oversight are key for NHTSA to carry out its broad safety mission.

Chairman McCaskill, this concludes my prepared statement. I will be happy to answer any questions you or other members of the Subcommittee may have.
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<thead>
<tr>
<th>Recommendation</th>
<th>Status</th>
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<tbody>
<tr>
<td>1. Revise the pre-investigation processes to ensure that the review of each complaint is recorded and that complaints are tracked to associated investigations in Artemis.</td>
<td>Closed</td>
<td>ODI provided documentation demonstrating that:</td>
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<tr>
<td></td>
<td>June 19, 2012</td>
<td>• Artemis tracks complaint reviews (who and when),</td>
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<td>• all relevant complaint numbers are included in the resume for each phase of an investigation, and</td>
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<td>• investigation process documents have been updated to reflect these policy changes.</td>
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<td>2. Establish pre-investigation processes for retaining and storing pre-investigation records, such as investigation proposals and insurance company data.</td>
<td>Closed</td>
<td>ODI provided documentation demonstrating that a process for using a case management system had been established to maintain pre-investigation data.</td>
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<td>Dec. 5, 2012</td>
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<td>3. Require that decisions made and actions taken by ODI Defect Assessment Panels are recorded, including justifications for not proceeding to investigations.</td>
<td>Closed</td>
<td>ODI provided documentation demonstrating that:</td>
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<tr>
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<td>Dec. 5, 2012</td>
<td>• Defects Assessment Panel minutes are added to a standardized form and uploaded to the repository for the relevant issue evaluation (IE),</td>
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<td>• IEs that do not proceed to investigation are marked with one of two codes: “minimal hazard indicated” or “no actionable trend indicated,” and</td>
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<td>• specifics concerning panel dates and IE dispositions are recorded in Artemis annotations for the appropriate IEs. These data can be analyzed and presented in report form.</td>
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<td>4. Establish systematic processes for determining when a third party or the Vehicle Research Test Center should be used to verify manufacturer information or assist in identifying a potential defect.</td>
<td>Closed</td>
<td>ODI provided revised office procedures including a framework for obtaining third-party resources.</td>
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<td>Mar. 27, 2012</td>
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<td>5. Revise the ODI investigation process to require justifications for continuing or closing investigations that exceed timeliness goals for preliminary evaluations and engineering analyses.</td>
<td>Closed</td>
<td>ODI established processes for justifying and documenting investigations that exceed timeliness goals.</td>
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<td>Mar. 27, 2012</td>
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<td>Recommendation</td>
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<td>6. Revise the ODI investigation process to establish criteria for documenting evidence, such as associated complaints, meetings with manufacturers and other stakeholders, and third-party analysis or testing conducted.</td>
<td>Closed</td>
<td>ODI provided documentation that it developed an “Investigation Documentation Checklist.” This checklist is a process for documenting evidence collected by the ODI investigators—including consumer complaints, meetings with manufacturers and third parties, and testing.</td>
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<td>7. Strengthen ODI’s redaction policy and process to better protect consumers’ personal information from public availability, such as by using automated redaction software.</td>
<td>Closed</td>
<td>ODI issued a revised redaction policy in August 2011.</td>
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<td>8. Conduct a workforce assessment to determine the number of staff required to ensure that ODI meets its objectives and determines the most effective mix of staff.</td>
<td>Open</td>
<td>ODI estimates that it will complete its workforce assessment by November 14, 2014.</td>
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<td>9. Develop a formal training program to assist ODI staff in acquiring knowledge and staying abreast of ODI processes and current and new automobile technologies.</td>
<td>Closed</td>
<td>ODI provided a copy of its new training plan. According to NHTSA officials, this plan will assist ODI in the development of its current and future workforce; ensure the continuity of institutional knowledge; and ensure that investigators and other ODI staff become proficient in new automotive, investigative, and vehicle safety technologies.</td>
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<td>10. Develop and implement a strategy for increasing coordination with foreign countries to enhance ODI’s ability to identify safety defects and to exchange information on foreign recalls.</td>
<td>Closed</td>
<td>ODI stated that it planned to form an informal working group to discuss issues of mutual interest to the international enforcement community. NHTSA would chair the group, and the group would meet twice a year—with the first meeting taking place on November 17, 2011.</td>
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Source: OIG analysis of NHTSA documentation