

## **Center for Auto Safety Detailed Points on DOT Inspector General Report**

- 1) Agrees 24 components too few & leads to inconsistent reporting which NHTSA doesn't monitor
- 2) Cites Honda EWR withholding w/o naming Honda
- 3) Early complaints on ignition switch in 2003 but overlooked – some had good description, some inconsistently categorized.
- 4) NHTSA doesn't do statistically valid analysis
- 5) Consumer complaints poorly screened, 90% set aside!
- 6) Poor ODI staff training led to defects being overlooked.
- 7) “ODI's investigation decisions lack transparency and accountability.”
- 8) NHTSA investigates defects likely to lead to recalls which results in much results in pre-investigation stages (NOT PUBLIC) by often poorly trained staff.
- 9) AA for Enforcement told ODI to look into why more GM ignition switch deaths but no one did because screener left agency & responsibility not reassigned.
- 10) Blanket condemnation of NHTSA's processes for collecting data to ensure completeness & accuracy.
- 11) Aggregate data can't be used to trace defects to a specific vehicle or incident – need more info. No requirement to report on incidents not linked to named component.
- 12) Component problem underlined. The airbag example with possible components (airbags, seats, electrical) is good even though it doesn't reference the 60% of all EWR D&I reports cite airbags and the potential for a mfr. to call it something else to mislead.
- 13) No guidance given to mfrs. who ask what code to use – unbelievable. More rulemaking necessary to straighten out. Aggregate data useless.
- 14) Non-dealer (i.e., mfr. rep) field reports most valuable but major inconsistencies in info reported. From a few lines to root cause analysis.
- 15) NHTSA has never used its authority to verify accuracy and completeness of EWR data. Relies on honor system. Cites example of one manufacturer (unnamed but it is Honda) being asked about inconsistencies between EWR and recall in late 2011 or early 2012. [See CAS Letter to NHTSA re: Honda Airbag Inflator Recalls - 12/5/11](#)

- 16) Cites Forest River AQ14-002 without naming Forest River in example of RV mfr who didn't report EWR info for 10 years.
- 17) Inaccuracies in consumer complaints including component categories that NHTSA offers no guidance on & does not provide for document uploads as does CPSC.
- 18) "From 2003 through 2013, GM submitted about 15,600 non-dealer field reports and about 2,000 death and injury reports on vehicles subject to the ignition switch recall—especially related to the 2005 to 2010 Chevrolet Cobalt."
- 19) Examples given of GM miscoding non-dealer field reports.
- 20) Examples given of GM miscoding fatal WI crash as other.
- 21) Miscoding of TSB as steering.
- 22) "From January 1, 2003, through February 7, 2014, ODI received 9,266 complaints involving the vehicles subject to the GM ignition switch recall—including 72 complaints indicating at least 1 injury and 3 complaints indicating at least 1 fatality. The majority of these complaints involved the 2005 to 2010 Chevrolet Cobalt and the 2003 to 2007 Saturn Ion."
- 23) Examples given of ODI contractors miscoding these complaints, ODI not following up and simply not recognizing clear safety complaints such as the one cited that said the ignition turn switch is poorly installed & the car would shut off while in motion.
- 24) Just chews up NHTSA's statistical analysis – fundamental flaw is NHTSA's failure to establish a base case of what the data test results would show if there were no defect. Doesn't use out-of-sample testing to see if a result that showed up in portion of aggregate data base showed up in others. "ODI has overlooked non-dealer field reports for months or even years if, for example, manufacturers submit the reports in formats that ODI's statistical test cannot process."
- 25) NHTSA relied on just one consumer complaint screener to examine all complaints (one every few seconds) & then hand off only 10% to 8 advanced screeners for more in-depth analysis, leaving 90% to go without in-depth analysis.
- 26) "ODI's process for initially screening consumer complaints leaves the office vulnerable to a single point of failure and the risk that complaints with potential safety significance may not be selected for further review."
- 27) 8 Advanced screeners often fail to rely on additional information such as EWR, reaching out to consumers or performing inspections. In 2013 NHTSA required annotations on complaints, but 57% were complaints that did not warrant further review because they lacked justification.

28) Examples of lack of training and supervision for advanced screeners is just appalling. None have statistical background or training. Screeners assigned to airbags had no airbag training. One was reassigned from child restraints. IG found no documentation of supervision. Division chief described his oversight of initial screeners work as minimal.

29) Designer of one statistical test said it should yield same results every time on same data set but it yielded different results.

30) “ODI staff missed opportunities to connect the ignition switch defect to air bag non-deployments because they did not consider all available information.” Cites WI SCI report; SCI report which was given to ODI but not considered by ODI, receipt of 13 non-dealer field reports on airbags, 12 of which were not analyzed until after the recall because GM submitted them in docx vs doc format which could not be read by NHTSA’s statistical test.

31) NHTSA’s initial screener only forwarded 3% (27) of GM recalled vehicle complaints to the advanced screeners who noted that 11 involved airbag non-deployment but did not further those because there was “no actionable trend” or “minimal hazard.”

32) NHTSA staff prepared 3 investigation proposals for the recalled vehicles but failed to go forward because “ODI staff did not establish the ignition switch defect as a potential root cause for these issues.”

33) “ODI has not developed guidance for applying the factors it established for opening an investigation. In addition, the factors that influence ODI’s decisions on whether to open an investigation are not transparent, and it is unclear who is accountable for these decisions. This was the case with ODI’s decision not to investigate the GM air bag non-deployment defect.”

34) “According to ODI’s Defects Assessment Division Chief, ODI considers three factors when proposing a vehicle safety defect investigation: (1) rate of consumer complaints,<sup>31</sup> (2) severity of the potential safety issue, and (3) identification of a potentially defective vehicle component or root cause. .. Attorneys in NHTSA’s Office of Chief Counsel state that while NHTSA must establish severity for all cases, it can establish either frequency or root cause to force a manufacturer to initiate a recall. However, according to ODI’s Defects Assessment Division Chief, all three factors should be met before proposing an investigation.” [CAS note: Incorrect – [see NHTSA litigated defect cases.](#)]

35) “Director of ODI can also unilaterally decide not to open an investigation after discussion with Defects Assessment Panel participants.” In June-July 2014, ODI Director rejected proposals to open investigations into loss of P/steering assist in 2007-11 vehicles where mfr did an extended warranty & intermittent loss of electrical power in 2012 models.

36) “One screener told us he uses his “gut feeling” when reviewing complaints to gauge the “appetite” of the office for specific issues. Another screener told us he only proposes

investigations that have the greatest chance of being selected to avoid the extra work of proposing investigations that are ultimately denied.”

37) “Three screeners said they are hesitant to propose investigations if similar proposals have been rejected in the past.” Examples were subframe rust in 2002-03 vehicles & hood latch failure.

38) “ODI officials prefer to open investigations that are most likely to result in a manufacturer recall—an assertion echoed by four of the eight screeners we spoke with. . . ODI’s focus on issues most likely to result in recalls creates the potential for missed opportunities to investigate issues that have serious safety implications. For example:” Headlamp outages on 2003-05 vehicles. Faulty brake lights.

39) “Targeting potential safety defects that most likely lead to recalls blurs the line between pre-investigative and investigative duties. . . . NHTSA’s Office of Chief Counsel stated that ODI may compel information from manufacturers during the pre-investigative stage . . . three screeners were unaware that their division has the authority to compel information from manufacturers without launching an investigation. . . .considerable investigative duties—such as research and engineering analysis work—are being performed in the pre-investigative phase, often by screeners who are not adequately trained and may not have access to complete information.”

40) “Untimely proceedings by the Defects Assessment Panel have delayed investigation decisions. . .The panel often reschedules meetings and according to some screeners, the meetings tend to be pro forma. For example, one screener stated the meetings focus on the reasons for not opening an investigation rather than reasons for opening one; another called the meetings “dog and pony shows. The panel also repeatedly delays decisions on proposals to obtain additional information.”

41) In August 2014, the panel reviewed a proposal to investigate a side airbag non-deployment that resulted in a fatality. The Director of ODI . . . requested additional information. By October, the manufacturer had responded to ODI’s questions, but an investigative division chief requested that an investigation not be opened until his team had completed an on-site inspection of the vehicle. [CAS note: If a manufacturer is asked to provide information on a potential defect, that communication is public under the FOIA and an investigation must be opened.]

42) “ODIs’ decisions are not transparent. Of the 56 investigation proposals for light vehicle safety defects in 2013, 32 were not investigated—18 of which lacked documented justifications for not investigating. While the panel may provide a reason for declining an investigation, such as “minimal hazard,” it does not document the evidence that supports its decision. In addition, a proposal may be rejected by investigation divisions, which do not always document reasons for declining to investigate. Lack of transparency exacerbates the problems created by reliance on precedent because screeners do not learn what management deems worthy of investigation.”

43) “Transparency and accountability are especially critical since ODI generally does not revisit proposals once they are declined for investigation. Screeners told us that there is a need for ever increasing numbers of incidents to consider reopening previously rejected investigative proposals.”

44) “While ODI identified air bag non-deployments as a potential safety issue, it did not identify or propose an investigation of the GM ignition switch issue. According to ODI staff, there were no discussions of the ignition switch defect prior to the February 2014 recall.”

45) “[W]eaknesses in ODI’s training and supervision of pre-investigation staff and its processes for identifying potential safety concerns and initiating investigations, as evidenced by NHTSA’s handling of the GM ignition switch defect, deter NHTSA from successfully meeting its mandate to help prevent crashes and their attendant costs, both human and financial.”