

U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

2703 Martin Luther King Avenue, SE
Washington, DC 20593
Staff Symbol: DCMS
Phone: (202) 372-4546
Fax: (202) 475-8326

5830

7-29-2015

MEMORANDUM

FINAL ACTION OF MAJOR INCIDENT INVESTIGATION REPORT INTO THE CIRCUMSTANCES SURROUNDING THE FATAL CAR ACCIDENT ON 07 MAR 2015 NEAR HOPEWELL TOWNSHIP NJ

The report of the Major Incident Investigation Single Investigating Officer, conducted under the provisions of the Major Incident Investigations Manual, COMDTINST M5830.4 (series) and CG DCMS memo 5830 of 06 Apr 2015, that investigated the circumstances surrounding the fatal car accident involving two international cadets in the vicinity of Hopewell Township, NJ on 07 Mar 2015, complies with applicable regulatory and statutory guidance. Accordingly, this report is approved.

A handwritten signature in blue ink, appearing to read "S. L. Stosz".

S. L. STOSZ
Vice Admiral, U. S. Coast Guard
Deputy Commandant for Mission Support

U.S. Department of
Homeland Security

United States
Coast Guard



Commander
United States Coast Guard
International Ice Patrol

1 Chelsea Street
New London, CT 06320
Phone: (860) 271-2631
Fax: (860) 271-2773

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6 JUL 2015

MEMORANDUM

From: *G. G. McGrath* CDR
G. G. McGrath, CDR
Single Investigating Officer

To: M. B. Lytle, RADM
Acting DCMS

Subj: MAJOR INCIDENT INVESTIGATION (MII) REPORT ON THE
CIRCUMSTANCES SURROUNDING THE FATAL CAR ACCIDENT ON 07 MAR
2015 NEAR HOPEWELL TOWNSHIP NJ

Ref: (a) Your ltr dtd 06 APR 2015
(b) COMDT COGARD Washington DC 261533Z Aug 13/ALCOAST 352

1. **Executive Summary:** On 07 MAR 2015 at 0002 (local) on New Jersey State Highway Route 31 south of County Road 518 in the vicinity of Hopewell Township, NJ 08525, Mishap Vehicle 1 (White 2008 Chevrolet Cobalt) and Mishap Vehicle 2 (Black 2008 Ford Focus) collided resulting in two deaths and three serious injuries. Mishap Vehicle 1 was travelling southbound on Route 31 when it encountered ice and spun into the northbound lane where it was struck by Mishap Vehicle 2. Coast Guard Academy (CGA) Passenger 1 and CGA Passenger 2 who were both travelling in Mishap Vehicle 1 died as a result of the collision. Both of these members were foreign exchange cadets from the Republic of Georgia. Serious injuries were sustained by CGA Driver 1, Mishap Vehicle 2 Driver, and Mishap Vehicle 2 Passenger. Both vehicles were totaled in the accident. The MII Single Investigating Officer found that icy road conditions were the cause of the mishap. Substantially contributing factors to the accident were speed of travel, tire wear, fatigue, and lack of trip planning.

2. Findings of Fact:

a. **Authority and Purpose:** This is an investigation convened by RADM Lytle in reference (a) and was conducted in accordance with reference (b) in order to inquire into the facts surrounding the Coast Guard mishap involving the fatal car accident on 07 MAR 2015 near Hopewell Township, NJ, to prepare a publically-releasable report, and to gather and preserve all available evidence for use in litigation, claims, disciplinary actions, administrative proceedings, and for other purposes. The investigation was conducted by a Single Investigating Officer, with guidance and support from a designated Legal Advisor and Recorder. This investigation involved gathering evidence from the Hopewell Township Police Department and conducting interviews of all involved parties including Police Department personnel, drivers of both vehicles, and other witnesses. A Mishap Analysis Board (MAB) was convened for this incident. Minimal interaction took place between that investigation and the MII. The only items that were

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shared were photographs of the crime scene sent to the MAB by the Hopewell Police Department and the MAB Witness List. All other MAB investigative activity, including witness interview summaries, evidence, and analysis was determined to be privileged and was not provided to this investigation. The Coast Guard Investigative Service (CGIS) conducted an investigation and shared that with the MII. The contents of the CGIS investigation are considered law enforcement sensitive and cannot be included in this report, but the report may be obtained through CGIS by referencing action number ACT-2015-03-002899-001. The Hopewell Police Department provided the Hopewell Police Department Investigation Report, the Hopewell Police Department Supplementary Investigation Report, and the New Jersey Police Crash Investigation Report. The MII Single Investigating Officer encountered several delays while conducting this investigation. Initially, CG-094 was required to make determinations on what evidence collected by the MAB could be provided to the MII. Upon advisement from the MII Legal Advisor, interviews did not commence until 16 APR 2015 for the first interview of CGA Driver 1's Company Chief followed by subsequent interviews beginning 23 APR 2015. In addition, a significant number of the witnesses interviewed for this investigation were not Coast Guard members. Therefore, in some cases, it was either difficult to reach the individuals, or they were unwilling at first to speak to the MII Single Investigating Officer. One of the most critical witnesses from the Hopewell Police Department, the primary responding detective, was unavailable for an extended period. The MII Single Investigating Officer chose to interview the responding Patrol Officers with the Hopewell Police Department, instead of this witness in order to continue the investigation.

b. **Accident Summary:** On 07 MAR 2015 at 0002 (local) on NJ State Highway Route 31 south of County Road 518 in the vicinity of Hopewell Township, NJ, Mishap Vehicle 1 and Mishap Vehicle 2 collided resulting in two deaths and three serious injuries. Mishap Vehicle 1 was travelling southbound on Route 31 when it encountered ice and spun into the northbound lane where it was struck by Mishap Vehicle 2. CGA Passenger 1 and CGA Passenger 2 who were both travelling in Mishap Vehicle 1 died as a result of the collision. Serious injuries were sustained by CGA Driver 1, Mishap Vehicle 2 Driver, and Mishap Vehicle 2 Passenger. Both vehicles were totaled in the accident.

c. **Background:** CGA Driver 1 and CGA Passenger 1 were members of the CGA Class of 2015. CGA Passenger 2 was a member of the CGA Class of 2017. The CGA Corps of Cadets were authorized leave, or vacation time, for Spring Break from their last military obligation on Friday, 06 MAR 2015 until liberty expired (based on cadet class rank) on Sunday, 15 MAR 2015. Just prior to Spring Break, the CGA Class of 2015 held their "Billet Night" on Thursday, 05 MAR 2015. At this event each spring, the graduating class receives their first duty station assignments as Coast Guard officers. CGA Driver 1 is a United States citizen who received an assignment to a Coast Guard unit. CGA Passenger 2 was from the Republic of Georgia and was scheduled to return to his home country to serve in the Georgian Air Force. The Billet Night dinner began at 1700 with all of the events of the evening concluding by approximately 2300 (Exhibits 1, 2). Alcohol was available at this event, and CGA Driver 1 consumed two beers. Following the event, CGA Driver 1 returned to the Chase Hall barracks where all cadets live. He worked on a paper that was due the following day and went to sleep at approximately 0030

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(local). CGA Driver 1 was planning to spend Spring Break back in his hometown of Oley, PA for his older brother's wedding on Saturday, 07 MAR 2015. CGA Passenger 1 and CGA Passenger 2 were planning to spend Spring Break sightseeing in Philadelphia and Washington, DC. The two Georgian cadets would sightsee in Philadelphia prior to travelling by bus to Washington, DC and then returning to CGA at the end of the week. CGA Driver 1 was planning to drive the two cadets to a hotel in Philadelphia and then drive to his parents' home in Oley (Exhibit 3).

d. Sequence of Events:

- (1) On 06 MAR 2015, CGA Driver 1 had been authorized a "late rack" following Billet Night the previous evening. This privilege had been given to the entire CGA Class of 2015 (Exhibit 3). "Late rack" is a cadet privilege approved for a variety of reasons. In accordance with the Regulations for the Corps of Cadets (SUPTINST M5215.5K), Section F-1-02.w, cadets using the "late rack" privilege are authorized to sleep until 0730 and must have the door to their cadet rooms in the Chase Hall barracks open by 0800 (Exhibit 4). Based upon this privilege, CGA Driver 1 awoke at approximately 0730 (Exhibits 3, 4).
- (2) CGA Driver 1 had Maritime Law Enforcement Class from 0800-0850 (Exhibit 5). His instructor noted that he did not seem tired and engaged in class as he normally did (Exhibit 6).
- (3) CGA Driver 1 had the Coast Guard Division Officer Course from 0900-0950 (Exhibit 5). His instructor also noted that he engaged normally in class and did not seem fatigued (Exhibit 7).
- (4) CGA Driver 1 had Atmospheric and Marine Science Class from 1100-1150 (Exhibit 5). His instructor commented that he was his usual self. The class watched a movie in class that day, and there was not a lot of opportunity for engagement. However, the instructor mentioned he would have remembered if CGA Driver 1 had fallen asleep or appeared inattentive (Exhibit 8).
- (5) At 1205, the Corps of Cadets had Lunch Formation followed by the Afternoon Meal at 1210 (Exhibit 9). Following lunch, liberty was granted to the Corps for those cadets without military obligations in the afternoon (Exhibit 10). CGA Passenger 1 had the Coast Guard Division Officer Course from 1250-1340 and Maritime Law Enforcement Class from 1450-1540 (Exhibit 11). CGA Passenger 2 had Physics II from 1250-1440 and Dynamics from 1450-1540 (Exhibit 11). CGA Driver 1 continued to work on his paper that was due at 1600 (Exhibit 3).
- (6) At around 1700, CGA Driver 1 departed the Chase Hall barracks to shovel his car out from snow that had fallen the previous day (Exhibit 3). A snowstorm throughout the day on 05 MAR 2015 resulted in approximately 7.3 inches of snow accumulation at CGA in New London, CT (Exhibit 12).
- (7) At approximately 1730, the group of three cadets departed CGA in Mishap Vehicle 1, CGA Driver 1's 2008 Chevrolet Cobalt, enroute to the hotel in Philadelphia, PA (Exhibit 3).

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- (8) On the drive, CGA Passenger 1 and CGA Passenger 2 requested to stop in Brooklyn, New York at the Tbilisi Restaurant, a Republic of Georgia restaurant, on Kings Highway. CGA Driver 1 agreed to go to this restaurant for dinner (Exhibits 3, 14).
- (9) After approximately 3.5 hours¹ of driving, the group of cadets arrived at the Tbilisi Restaurant. The group spent approximately 1-2 hours eating dinner. CGA Driver 1 indicated that no one in the group consumed alcohol (Exhibits 3, 14).
- (10) The menu for Tbilisi Restaurant indicates that beer and wine are available for purchase (Exhibit 13). During a separate call by the MII Single Investigating Officer to the owner on 23 APR 2015, she noted that she did not remember three cadets from CGA dining at the restaurant on 06 MAR 2015.
- (11) After departing Brooklyn, New York, the group planned to head on Interstate 95 to Philadelphia. However, after coming through a toll booth, they made a wrong turn and ended up on back roads off of the highway (Exhibit 3). CGA Passenger 1 utilized the GPS from the cell phone of CGA Driver 1 to gain directions in an attempt to make it back to Interstate 95 (Exhibits 3, 14). The vehicle traveled on New Jersey State Highway 202 to New Jersey State Highway 31 (Exhibit 14). Figure 1 shows the approximate route of travel of the three cadets.

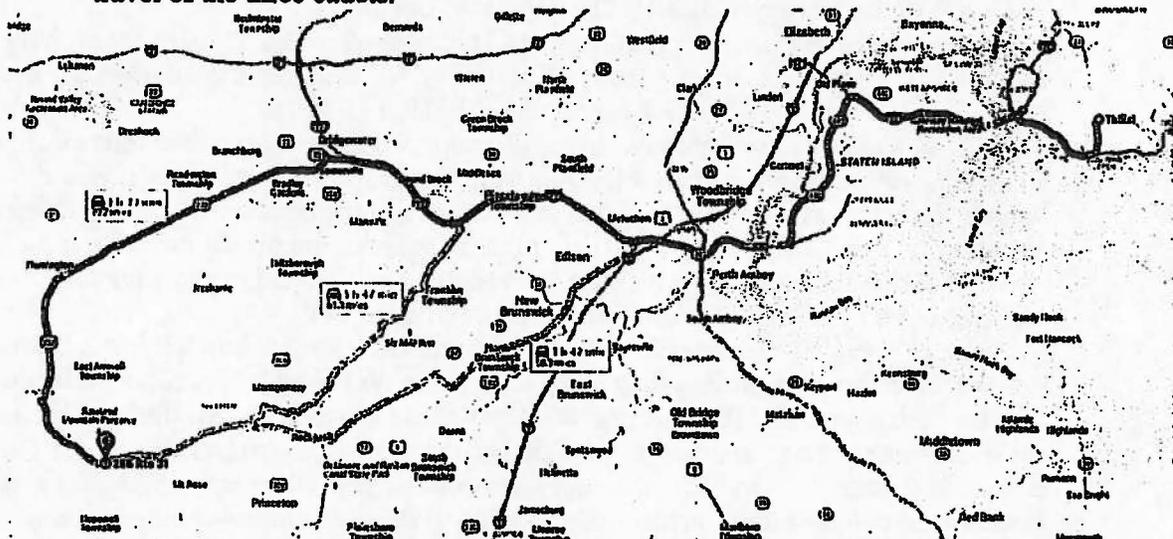


Figure 1: Cadets Approximate Route of Travel from Tbilisi Restaurant on Kings Highway in Brooklyn, NY to the crash site in Hopewell Township, NJ (Picture taken from Google Maps).

- (12) CGA Driver 1 was awake and alert (Exhibit 3). CGA Passenger 1 was reading off the directions from the cell phone from the front passenger seat (Exhibits 3, 14). Both front seat passengers were wearing their seatbelts (Exhibits 2, 14, 15). CGA Passenger 2 was

¹ During an interview for this investigation, CGA Driver 1 stated the drive time between the CGA and restaurant was approximately 1.5-2 hours, Exhibit 3. However, in an earlier police interview, only a few days after the accident when his recollection was fresher, he stated the drive time was 3.5 hours, Exhibit 14. It is more reasonable to believe that the drive from New London, CT to Brooklyn, NY would take over three hours on a typical Friday evening.

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- lying down in the back seat, sleeping off and on (Exhibit 3). By all indications, he was not wearing his seatbelt (Exhibit 15).
- (13) In the area where Mishap Vehicle 1 travelled, Route 31 is a designated 45 mile per hour, single lane state highway in each direction with a double yellow line indicating a no passing zone. This section of Route 31 has a slight grade in the road with a slight curve and no street lights. It is a back road constructed of blacktop pavement with fields and trees and no major landmarks or businesses (Exhibits 14, 16). The ground to either side of the highway was covered in snow on 06-07 MAR 2015 (Exhibit 14).
- (14) On Route 31, the road was clear and dry with no obstructions or damage (Exhibits 3, 14, 15, 16). Just prior to mile marker 255, a patch of ice was present in the southbound lane. Sunny conditions during the day on 06 MAR 2015 had caused the snow to melt and the resulting water to run from the shoulder to the west of the southbound lane on to the highway (Exhibit 17). The daytime high temperature in Hopewell Township, NJ on 06 MAR 2015 was 24°F (Exhibit 18). After sunset, the temperature quickly cooled to 8°F, and this snow melt froze (Exhibit 17). The icing started on the southbound shoulder and gradually extended into the entire southbound lane and partially into the northbound lane. The patch of ice was approximately 30 yards long (Exhibit 14).
- (15) CGA Driver 1 was travelling down Route 31 at approximately 55-60 miles per hour (Exhibits 14, 15). CGA Driver 1 indicated that he typically drives at 5-10 miles per hour (Exhibits 14, 15) or "10%" over the speed limit (Exhibit 3).
- (16) Mishap Vehicle 1 approached a slight hillcrest in the roadway and then followed into a slight downward curve to the left (Exhibit 16). Coming down this slight curve, the vehicle came into contact with the patch of ice in the southbound lane of Route 31 near mile marker 255. CGA Driver 1 lost control of his vehicle, and the car turned to the left, skidding across the northbound lane at a right angle to northbound traffic with the passenger side of Mishap Vehicle 1 sliding south (Exhibit 14).
- (17) Mishap Vehicle 2 was travelling northbound on Route 31. Mishap Vehicle 2 Driver noticed an oncoming vehicle sliding completely sideways (Exhibit 16) across the median into the northbound lane (Exhibit 19). Mishap Vehicle 2 Passenger saw the headlights of the oncoming car move in a way that caught her attention, likely when CGA Driver 1 lost control of the car (Exhibit 20). Although Mishap Vehicle 2 Driver was driving the speed limit, he did not have time to react (Exhibit 19), and the two vehicles collided around midnight on 07 MAR 2015 (Exhibits 14, 16, 17).
- (18) The passenger side of Mishap Vehicle 1 collided with the front of Mishap Vehicle 2. The point of maximum engagement between the two vehicles was so great that it caused gauging in the northbound lane. Gauging occurs when one or both vehicles are forced into the pavement due to the impact of the accident (Exhibits 14, 15).
- (19) Due to the force of the collision, Mishap Vehicle 1 spun counterclockwise, nearly in a full circle, until reaching its final resting stop in the northbound lane. The vehicle was facing mostly southwest, with the right front passenger tire on the double yellow center line, at an approximate 45 degree angle to the southbound lane (Exhibit 14). The resting place of Mishap Vehicle 1 was several hundred feet south of the patch of black ice (Exhibit 15).

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(20) Mishap Vehicle 2 was forced to the east and off the road in the northbound lane approximately eight feet from Mishap Vehicle 1. The two rear tires were on the blacktop on the shoulder of the road with the rear bumper parallel to and approximately one foot from the fog line (Exhibit 16). More than half of the vehicle was off the road and at rest in the grass shoulder which at the time was snow-covered. The front of the vehicle was facing east and was at an angle slightly greater than 90 degrees to the roadway (Exhibit 14). The diagram in Figure 2 shows the approximate resting site of both vehicles in the roadway and the location of gauging. Figure 3 shows the section of the highway where the crash occurred from Google Maps. Additional views of the crash site area from Google Maps are provided as Exhibit 21. The photographs in Figures 4, 5, and 6 show the damage to and position of both vehicles involved in the accident.

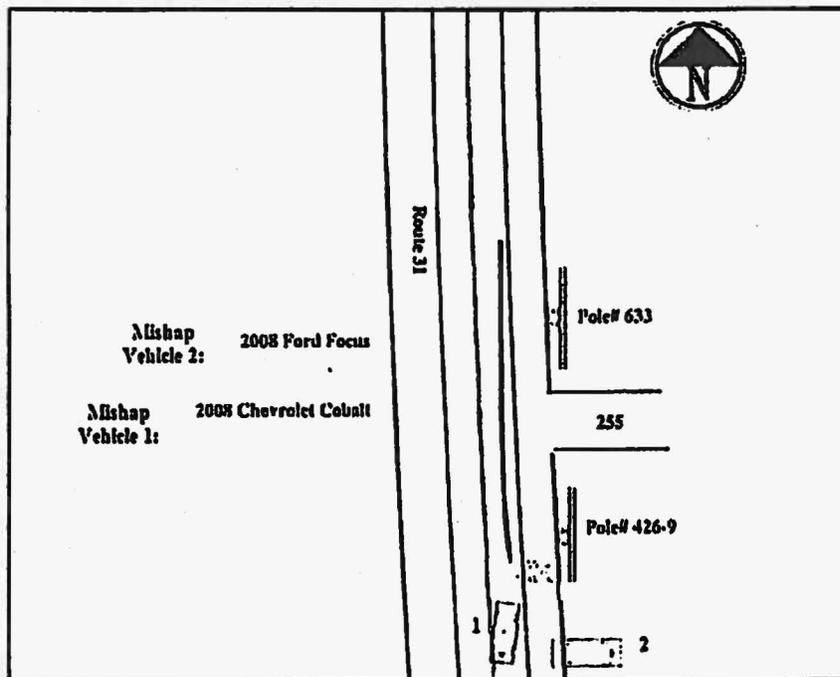


Figure 2: Final Rest Diagram of Crash Site taken from New Jersey Police Crash Investigation Report and relabeled for this investigation.

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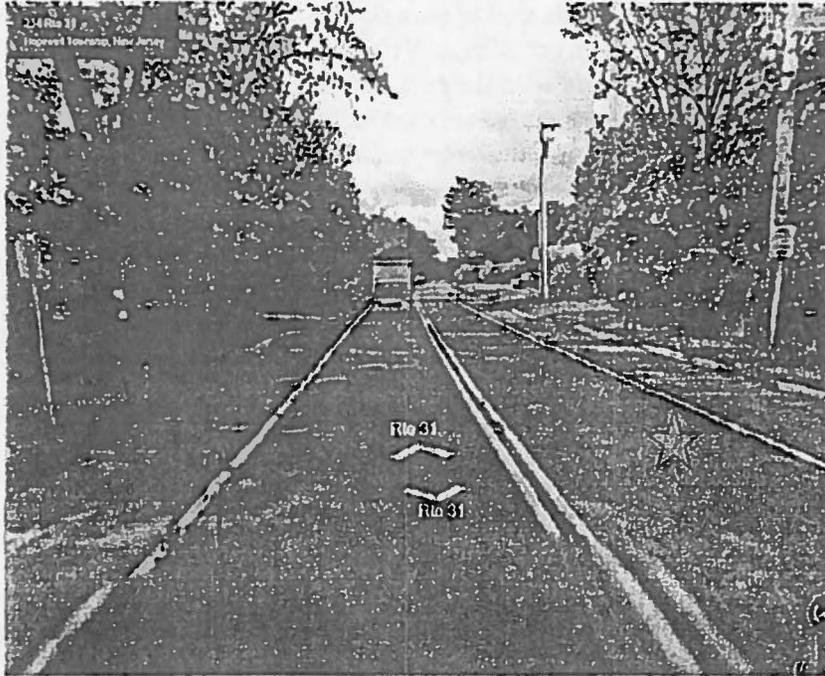


Figure 3: Location of crash site looking northbound on NJ Route 31. The point of maximum engagement between the two vehicles is indicated by the red star ★ (Picture taken from Google Maps).



Figure 4: Photograph from Hopewell Police Department of the crash scene.

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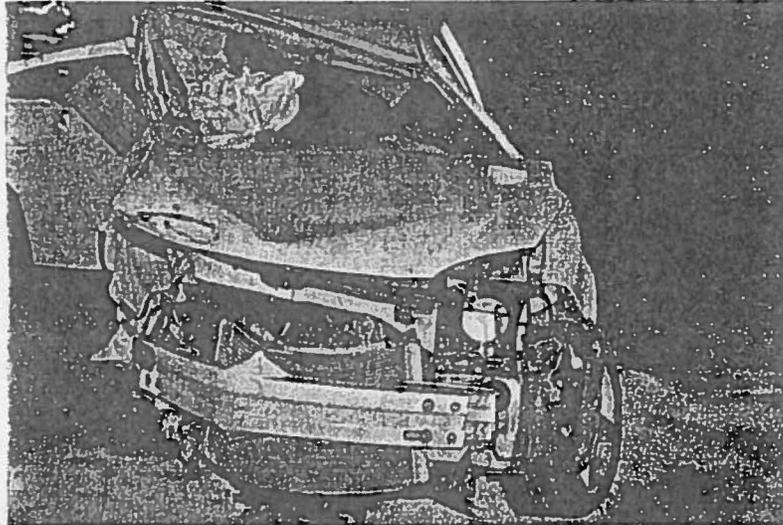


Figure 5: Photograph from Hopewell Police Department of Mishap Vehicle 1.

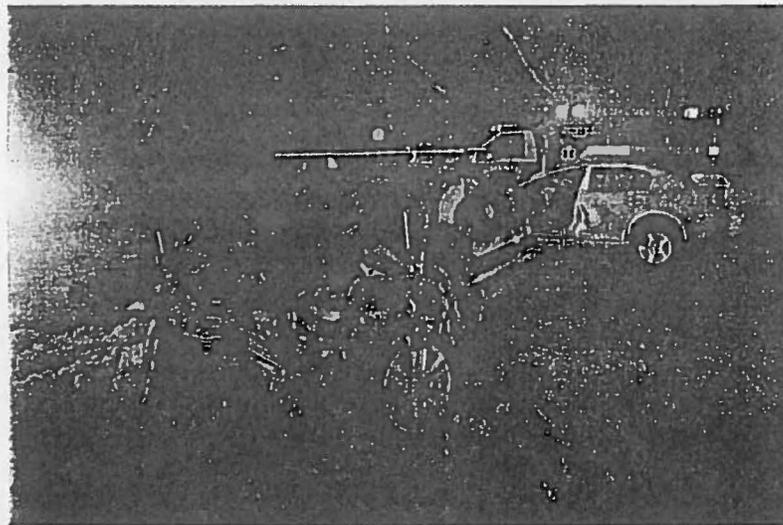


Figure 6: Photograph from Hopewell Police Department of Mishap Vehicle 2.

- (21) There were no witnesses to the accident other than the occupants of the vehicles (Exhibit 17), but multiple individuals reported the incident to 911 following the crash.
- (22) Before HPD arrived on scene, Post-Accident Witness was driving southbound on Route 31. He was travelling the speed limit because he had been pulled over by the police for speeding in the same general vicinity the previous week (Exhibit 22). He noticed some fog near an open field on the right side of the road and white covering the ground. He then noticed a large amount of ice covering the southbound lane which caused his vehicle to slip slightly. After momentarily losing control of his car, he regained control and proceeded south. He then saw a white car in the middle of the road facing slightly sideways. After driving past, he realized that the vehicle had been

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involved in a motor vehicle crash, and he turned around to come back and make sure that someone had called 911. Once confirming that 911 had been called, Post-Accident Witness exited the area due to the formation of congestion. As he was departing, he heard sirens coming towards him (Exhibit 22). The HPD Patrol Officer who responded noted that Post-Accident Witness was likely able to maintain control of his vehicle while transiting over the patch of ice because he was travelling at an appropriate speed for the road conditions (Exhibit 15).

- (23) When the HPD officers arrived on scene at 0002 on 07 MAR 2015 to assess the situation, all five victims were trapped in their vehicles. Mishap Vehicle 1 contained three of these victims. CGA Driver 1 was conscious, but appeared confused and in shock. He did not have any visible injuries, but he was unable to answer any questions posed by the responders as to what had happened in the accident (Exhibit 16).
- (24) CGA Driver 1 was extricated from the vehicle (Exhibits 14, 17) and taken by ambulance to Capital Health Regional Medical Center (Exhibit 23). He was given multiple CT scans with all normal results (Exhibit 24). He was released to his parents at approximately 1000 on 07 MAR 2015. He slept the remainder of the day, did not attend his brother's wedding, and spent the rest of the week recovering from his injuries prior to returning to CGA on 15MAR15 (Exhibit 25).
- (25) CGA Passenger 1 was heavily entrapped with severe intrusion into the front passenger side compartment. He was officially pronounced dead at the scene at 0056 on 07 MAR 2015 by a doctor of the Capital Health Regional Medical Center by way of the responding paramedics (Exhibits 17, 23).
- (26) CGA Passenger 2 was partially ejected through the passenger side rear window which was completely shattered. After being extricated from the vehicle by emergency personnel (Exhibits 16, 17), first aid was attempted on CGA Passenger 2, and he was airlifted to Capital Health Regional Medical Center. He was unresponsive to all treatment, and he was officially pronounced deceased at 0150 on 07 MAR 2015 by a doctor at the hospital (Exhibits 16, 17, 23).
- (27) Both individuals in Mishap Vehicle 2 were trapped in their compartments, but were alert and conscious. The front and side airbags had both deployed. The driver and passenger seats were laid back on a 45-degree angle due to the impact of the crash. Both victims were extricated from the vehicles by Hopewell Fire and emergency personnel (Exhibits 16, 17). Mishap Vehicle 2 Passenger was airlifted to Robert Wood Johnson University, New Brunswick in critical condition and was treated for a broken left femur. Mishap Vehicle 2 Driver was airlifted to Capital Health Regional Medical Center in critical condition (Exhibit 23). He received surgery for internal injuries (Exhibit 19).
- (28) The following agencies responded to the scene: New Jersey State Police Department, New Jersey Department of Transportation, Mercer County Prosecutor's Office, Mercer County Medical Examiner's Office, Hopewell Borough Emergency Medical Services, HPD, Pennington Borough Police Department, Pennington Fire Department, Pennington First Aid Squad, Lambertville-New Hope Ambulance Rescue Squad, West Amwell Police Department, and Life Medic (Exhibit 17).
- (29) While investigating the icing condition in the southbound lane, the responding detective noticed tire marks visible in the northbound lane leading up to the crash

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- location. The detective's investigation revealed that these tire marks were made by Mishap Vehicle 1 as it was traveling south in the northbound lane (Exhibits 14, 15).
- (30) Route 31 was closed at the intersection of County Route 518 and at the intersection of County Route 612 to all northbound and southbound traffic following the crash for approximately five hours using fire and police department resources (Exhibits 14, 15, 17). The New Jersey Department of Transportation (NJ DOT) was contacted to shut down the highway between Route 612 and Route 518, to provide a diversion team, to clean up fluids spilled from the vehicles, and to clean up the ice in the southbound lane (Exhibits 16, 17, 26, 27).
- (31) One half ton of salt was applied to the roadway to clear the icing condition. NJ DOT worked for approximately 3.5 crew hours to complete the job (Exhibit 27).
- (32) Both vehicles were towed from the scene and were later inspected by mechanics from HPD while located at the garages of the towing companies (Exhibits 17, 31, 32).
- (33) CGA Driver 1 was issued two citations for the accident (Exhibits 14, 16, 17). CGA Driver 1 was found to be at fault for the crash as a result of losing control of his vehicle and driving at a speed unsafe for the road conditions. He was issued a ticket for violating New Jersey statute "39:4-97 Careless Driving – Likely to Endanger Person or Property" (Exhibits 17, 28). He was also driving on a State of Pennsylvania registration that had expired on 01 JAN 2015 and was issued a ticket for violating New Jersey statute "39:3-17 Touring Privileges of Non-Resident Chauffeurs or Drivers" (Exhibits 17, 28).
- (34) As of the date of this report, these citations are awaiting disposition by the Mercer County Prosecutor's Office who has the ultimate authority in how to proceed. All indications are that criminal charges will not be forthcoming because there was no wanton disregard for public safety and/or the use of alcohol or drugs (Exhibit 15). All motor vehicle accidents involving fatal crashes are required to be forwarded to the Prosecutor's Office for review. If criminal charges are not completed, the summonses will be returned to Hopewell Township Municipal Court for disposition. There is no timeframe on when that might occur (Exhibit 29).

e. **Maintenance:** Mishap Vehicle 1 had received oil changes since being purchased by CGA Driver 1 in the summer of 2014. However, it had not had a major service completed, and the tires were the same tires purchased with the vehicle. CGA Driver 1 indicated that he planned to have the vehicle serviced over Spring Break (Exhibit 3). There were numerous recalls in place for Mishap Vehicle 1 from Chevrolet (Exhibit 30). None had been addressed prior to the incident. None of these recalls appeared to have been a factor in the incident. The tires on Mishap Vehicle 1 were those purchased with the vehicle (Exhibit 3). They were all weather tires and had not been changed for the winter months. The tires on both vehicles appeared to be in the tolerable range for tread depth (Exhibits 14, 15). The front tires on Mishap Vehicle 1 were "noticeably worn," but they were not considered to be "bald or otherwise inappropriate," according to the HPD (Exhibit 15). The tread wear on all tires of Mishap Vehicle 1 was within New Jersey state tolerance at between 3/32 and 4/32 (Exhibit 31). The tread wear on Mishap Vehicle 2 was adequate at 11/32 (Exhibit 32). According to state standards across the

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United States, 2/32 is considered bald (McCarron, 2007)². Blythe and Sequin (2006)³ noted that "research suggests that tires with less than 4/32 of an inch tread depth may lose approximately 50 percent of available friction in those circumstances, even before hydroplaning occurs."

f. **Vehicles:** Both vehicles were totaled in the accident. The initial impact between the two vehicles was the entire front of Mishap Vehicle 2 and the passenger side of Mishap Vehicle 1 at a 90-degree angle. Mishap Vehicle 1 sustained heavy passenger side front and rear damage. There was heavy intrusion into the passenger side, and it was leaking fluids that ran across the northbound lane into the shoulder (Exhibits 14, 16, 17). Mishap Vehicle 2 sustained heavy front end damage. All five individuals involved in the crash were trapped in the vehicles when police arrived on scene, and the four victims who were alive when responders arrived were extricated from the vehicles by removing four of both vehicles' doors (driver and right rear doors of Mishap Vehicle 1 and driver and front passenger doors of Mishap Vehicle 2) (Exhibits 14, 16, 17). Both vehicles were towed from the scene and inspected by the HPD Mechanic. Both vehicles appeared to be in proper working order, and there were no obvious defects that would have contributed to the crash (Exhibit 14). The passenger air bag deployed in Mishap Vehicle 1. Both the front and side airbags deployed in Mishap Vehicle 2 (Exhibit 16).

g. **Weather:** Hopewell Township, NJ experienced a mix of rain, sleet, and snow on 04-05 MAR 2015. NJ DOT plowed snow off of Route 31 following this weather event, and residual salt caused the north and southbound lanes and shoulder to be white in color (Exhibit 14). On 06 MAR 2015, the high temperature was 24°F, and conditions were sunny (Exhibit 18). The sun was out during the day and caused snow melt into the southbound lane. This melt froze into the evening causing an ice condition in only the southbound lane (Exhibits 14, 15, 16, 17) Through the evening, it became very cold, very fast, and by midnight, it was clear and approximately 8°F (Exhibits 14, 15, 18). Post-Accident Witness noted some fog while travelling southbound on Route 31 shortly after the accident (Exhibit 22). However, the responding police officers noted that it was clear, and visibility was several hundred feet at a minimum (Exhibits 14, 15, 16, 17).

h. **Driver Qualifications:** Mishap Vehicle 2 Driver holds a New Jersey Driver's License (Exhibit 16). CGA Driver 1 holds a valid Pennsylvania Driver's License (Exhibit 33). CGA Driver 1 was never prescribed any medication for the entire four years that he was a student at CGA. He is extremely myopic (near-sighted) and usually wears contacts or glasses. On the night of the accident, he was wearing his glasses. His prescription is -5.25 diopters in the right eye, and -3.25 diopters in the left eye with no astigmatism, which would imply that he is more than 20/400 uncorrected in both eyes. He corrects to 20/20 in both eyes (Exhibit 24).

²McCarron, K. (2007, October 22). *Tread depth debate goes on*. Retrieved June 4, 2015, from Dunn Tire: <http://www.dunntire.com/learning-center/Recommended-Tread-Depth>.

³Blythe, W., & Sequin, D. E. (2006). Commentary: Legal Minimum Tread Depth for Passenger Car Tires in the U.S.A. - A Survey. *Traffic Injury Prevention*, 107-110.

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i. **Medical:** CGA Driver 1 woke on 06 MAR 2015 at approximately 0730. After attending three classes in the morning and working on a paper all afternoon, he shoveled his car out from the snowstorm the previous night and left the Academy at approximately 1730. Upon departure, he had already been awake for ten hours. Including a 1-2 hour dinner in Brooklyn, the group of cadets was traveling for a little over 6.5 hours at the time of the crash. CGA Driver 1 had been awake for approximately 16.5 hours (Exhibit 3).

The mishap resulted in the deaths of CGA Passenger 1 and CGA Passenger 2. Both deaths were ruled accidental as a result of the crash by the Capital Health Regional Medical Center doctor (Exhibit 14). CGA Passenger 1 died immediately from multiple traumatic injuries, including massive head trauma and a compound fracture of his right leg. He was pronounced dead at 0056 at the scene of the accident (Exhibits 14, 16, 17, 23, 24). CGA Passenger 2 died from multiple traumatic injuries, including massive head trauma and severe damage to his right arm. He was pronounced dead at 0150 after being airlifted from the scene to Capital Health Regional Medical Center Emergency Room Trauma Unit where he was unresponsive to any and all treatment (Exhibit 14, 16, 17, 23, 24).

Mishap Vehicle 2 Driver experienced a broken ulna, perforated bowels, and a cervical strain in his back (Exhibit 19). Mishap Vehicle 2 Passenger experienced a broken left femur (Exhibits 16, 17, 20).

CGA Driver 1 suffered a concussion with brief loss of consciousness and some retrograde and anterograde amnesia. He was conscious during the extrication from his vehicle. He also had hematomas/contusions to his left knee and right elbow with small effusions. He suffered contusions to his right wrist and mid-right lower leg. He was advised by his doctor at CGA to take two over-the counter Naproxen 220mg pills twice a day with food for pain. He returned to CGA on 15 MAR 2015 and was seen at the U.S. Coast Guard Health, Safety, and Work Life (HSWL) New London Clinic on 17 MAR 2015 for a duty status determination. At that time, he was still sore and bruised, but had no further effects from the concussion, to include no headache, visual changes, dizziness, or nausea. He returned to school and athletics. He was re-evaluated by a neurologist on 29 APR 2015 for any after effects, but the neurologist cleared him as totally healthy and without restrictions (Exhibit 24). In his interview, he noted that he did not remember much from when his vehicle swerved to the left until he awoke in the hospital around 0700 (Exhibit 3).

In accordance with the Coast Guard Administrative Investigations Manual (COMDTINST M5830.1A), the deaths of both cadets and the injuries to the third cadet were all in the Line of Duty (LOD) and Not Due to Own Misconduct. No lifestyle factors were found to contribute to the accident.

j. **Operations and Supervision:** All Coast Guard Message (ALCOAST) 300/07 (Enclosure 1) and Coast Guard Flag Voice 309 (Enclosure 2) announced the availability of the Coast Guard Travel Risk Planning System (TRiPS), an on-line risk assessment tool that provides feedback on proposed motor vehicle excursions. The Coast Guard Safety and Environmental

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Health Manual (COMDINST M5100.47A) only requires military members on permanent change of station orders who will be traveling more than 400 miles in their private motor vehicle to complete a TRiPS assessment and have their supervisor review and approve the assessment prior to detaching from their command. However, Section 5-E-7, the Regulations for the Corps of Cadets (SUPTINST M5215.5K) (Exhibit 34) requires the use of TRiPS for all members of the Corps of Cadets driving privately-owned motor vehicles for distances of 100 miles or greater. In accordance with the Regulations for the Corps of Cadets (SUPTINST M5215.5K), CGA Driver 1 was required to complete a TRiPS assessment for this trip and submit it to his Company Chief. The Company Chief is a senior enlisted member responsible for the oversight of approximately 120 cadets in his/her company. No TRiPS assessment was completed for this trip. This section of the Regulations for the Corps of Cadets (SUPTINST M5215.5K) is not regularly followed by the Corps of Cadets (Exhibit 2). An assessment of the cadets' trip conducted after the incident noted that it was a low-risk trip. However, all factors were not included in the assessment, including the traffic that was encountered or the length of the stop in Brooklyn (Exhibit 35).

In accordance with the Coast Guard Safety and Environmental Health Manual (COMDTINST M5100.47A), ALCOAST 380/11 (Enclosure 3), and ALCOAST 496/14 (Enclosure 4), and Section F-1-02.al.1(c) of the Regulations for the Corps of Cadets (SUPTINST M5215.5K) (Exhibit 36), all Coast Guard members are required to wear seat belts in a moving vehicle, whether they are off or on duty and regardless of their seating position within the vehicle. There are no requirements for drivers of motor vehicles to ensure that their passengers are wearing seat belts.

k. Human Factors Analysis: CGA Driver 1 was found to be driving over the speed limit and too fast for the road conditions. This determination was made by HPD based on the admission of CGA Driver 1 himself and the evidence found on scene. However, his driving was determined to be "careless" and not "reckless" because there was no wanton disregard for safety (Exhibits 15, 37). The state of New Jersey does not automatically dictate a speed for reckless driving. Officers take the totality of the circumstances (weather, road conditions, traffic, time of day, type of road, etc). In this incident, the HPD and the Mercer County Prosecutor's Office agreed that, although CGA Driver 1 admitted to exceeding the speed limit, the evidence did not support a determination that the speed was "excessive" or "reckless" in nature (Exhibit 37).

There were no toxicology tests performed because there was no evidence at the crash scene to indicate probable cause for drug or alcohol use by any parties involved. There was also no evidence of cellular phone use by either driver. HPD determined that CGA Driver 1 was not distracted at the time of the incident because he was "negotiating the curve properly" (Exhibits 14, 15).

The Department of Defense Human Factors Analysis and Classification System (DOD HFACS) was utilized to analyze the human factors contributing to this incident.⁴ The following factors

⁴ The DOD HFACS analysis and classification system is also available online at http://www.public.navy.mil/comnavsafecen/Documents/aviation/aeromedical/DoD_hfacs.pdf.

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outlined in the DOD HFACS were considered to be possible human factors that contributed to this motor vehicle accident: PC213 Get-Home-Itis/Get-There-Itis, PP109 Mission Planning, PP205 Inadequate Rest, and SI001 Leadership/Supervision/Oversight Inadequate.

1. **Additional Areas of Concerns:** No additional areas of concern were noted during this investigation.

3. Statement of Opinion:

a. **Cause of the Mishap:** I find by clear and convincing evidence that the cause of the mishap was the large patch of ice in the southbound lane of Route 31. This ice was present unexpectedly on a roadway that was otherwise free of ice. Another driver travelling on the highway on the night of 06 MAR 2015 also encountered this patch of ice. The ice was so severe that the police officers on scene were unable to walk on it. The NJ DOT spent 3.5 work hours and a half of ton of salt to clear this hazard. It extended completely across the southbound lane. All three police reports, the Hopewell Police Department Investigation Report, the Hopewell Police Department Supplementary Investigation Report, and the New Jersey Police Crash Investigation Report, found that the ice on the highway was a factor in the crash. (Findings of Fact (d)(13), (14), (16), (21), (23), (31), (g)).

b. **Substantially Contributory Factors:** I find by a preponderance of the evidence that each of the following factors substantially contributed to the mishap. The factors are listed in order of their significance in contributing to the mishap.

(1) Speed of Travel – The speed that CGA Driver 1 was travelling was too high for the road conditions. Post-Accident Witness was able to successfully maintain control of his vehicle over the patch of ice because he was travelling at an appropriate speed for the road conditions. Although CGA Driver 1's speed did not show any wanton disregard for public safety, the police did cite him for Careless Driving for driving at a speed of 55-60 miles per hour, 10-15 miles per hour above the speed limit. The Coast Guard Academy and the city of New London, CT experienced over seven inches of snow during the winter storm the previous day. These conditions should have triggered CGA Driver 1 to consider possible slick areas during the drive to Philadelphia, PA. While a contributing factor, the speed was not the cause of the accident because it was not reckless in nature, and CGA Driver 1 had no intent to do harm (Findings of Fact (d)(13), (15), (21), (23), (31), (33)).

(2) Tire Wear – The tires on Mishap Vehicle 1 were nearly bald. Given the wintery conditions, these tires were simply worn too far to adequately grip the road. Based on the research completed by Blythe and Sequin (2006)², tires in this condition could have contributed to the sliding of the vehicle once it encountered the ice on the road. In addition, CGA Driver 1 had not taken the 2008 Chevrolet Cobalt to have four recalls completed that were dated from September 2012 through April 2014. No service or maintenance, other than oil changes, had been completed on the vehicle since purchase. This pattern indicates a lack of care for the condition of the vehicle (Findings of Fact (d)(21), (32), (e)).

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(3) **Fatigue** – CGA Driver 1 had been up until 0030 working on a paper on the evening of 05 MAR 2015 following the events of Billet Night. Although he got approximately seven hours of sleep, he was busy throughout the day on 06 MAR 2015 attending three classes and finalizing his paper before departing CGA on Spring Break. The cadets took approximately 3.5 hours to get to Brooklyn after driving through traffic, spent 1-2 hours at dinner, and then headed for Philadelphia. The DOD HFACS Factor of PC213 Get-Home-Itis/Get-There-Itis may have come into play at this point in addition to PP205 Inadequate Rest. CGA Driver 1 was trying to get home to prepare to be in his brother's wedding the following day. A drive that would normally take approximately 4.5 hours for the entire trip had already taken 6.5 hours at the time of the accident. CGA Driver 1 still had to travel to the Georgian cadets' hotel in Philadelphia and then drive to his parents' home in Oley, PA. This drive is approximately 93 miles or 1.5-2 hours. If the accident had not occurred, he would have arrived to his final destination at around 0200, having been awake for 18.5 hours (Findings of Fact (d)(1-9), (11-12)).

(4) **Inadequate Trip Planning and Continual Risk Evaluation** – The three cadets did not plan their travel on 06 MAR 2015 in a safe manner, and Factor PP109 Mission Planning of the DOD HFACS was a result. While the cadets took some preventative safety actions, such as stopping to rest, not consuming alcohol, and driving with passengers, there were additional factors that they could have done to more adequately prepare for the trip and safely execute the trip once they departed CGA. During the planning, no TRiPS assessment was completed although it is required to be done in accordance with the Regulations for the Corps of Cadets (SUPTINST M5215.5K). In addition, driving from Southeastern Connecticut through New York City to Philadelphia on a Friday evening is a trip certain to encounter heavy traffic volume. Without traffic, this trip would take approximately 2.3 hours. However, with the heavy traffic normal on a Friday evening, it took the cadets 3.5 hours. If a TRiPS assessment had been completed, the Company Chief of CGA Driver 1 may have been able to point out the traffic concern. Because a TRiPS assessment was not completed, CGA leadership was unable to provide this guidance, and Factor SI001 Leadership/Supervision/Oversight Inadequate of the DOD HFACS came into play. In addition, part of the TRiPS assessment is to have the member's supervisor inspect the vehicle prior to departure. If the TRiPS had been completed, the Company Chief would also have had the opportunity to inspect CGA Driver 1's vehicle and may have noted the inadequate tire tread depth on the vehicle. Part of their preparation should also have been to check the weather on the route which was not done. After the snowstorm on Thursday (05 MAR 2015), the cadets could have reconsidered the weather condition for the drive. Finally, once the cadets departed CGA, there was a lack of continuous risk evaluation during the trip's execution. For example, the cadets did not make the ideal decision when deciding to stop in Brooklyn for a lengthy 1-2 hour meal after already being delayed by traffic. If they had chosen to eat at a rest stop off of the highway for a short stop, they would have been that much further along in their trip, approximately two hours earlier in the evening (Findings of Fact (d)(8), (9), (11), (e), (j)).

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c. Ultimately, I believe that the cause of this mishap was the patch of ice on the roadway. A combination of the factors of speed of travel, tire wear, fatigue, and lack of trip planning substantially contributed to the occurrence of the mishap.

4. Signature: The Findings of Fact and Opinions are those of the MII Single Investigating Officer and do not constitute an official determination by the U.S. Coast Guard concerning this mishap.

Gabrielle G. McGrath

Gabrielle G. McGrath
Commander, U.S. Coast Guard
MII Single Investigating Officer

06 JUL 15

Date

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Enclosures: (1) ALCOAST 300/07
(2) Coast Guard Flag Voice 309
(3) ALCOAST 380/11
(4) ALCOAST 496/14
(5) Evidence Inventory
(6) MII Witness List
(7) MII Members List

