Pedestrian Safety Advisory Council

Meeting 9 Summary

February 22, 2017, 10 am – 2:30 pm

**Attending:** Janet Shull, Josh Diekmann, Charlotte Claybrooke, Karen Wigen, Paul Taylor, David Delgado, Dungho Chang, Darrin Grondel, Ron Kessler, Marc Anderson, Julia Reitan, Michael Dornfeld, Shelly Baldwin, Scott Waller, Staci Hoff, Geneva Hawkins, Heidi Keller (facilitator)

**Meeting Focus: Improve Pedestrian Data** (Focus Area 4)

Use a case study approach to become familiar with available data sources for pedestrian fatalities. Today’s exercise focused on *Impaired Pedestrians*. They represent 44% of pedestrian fatalities, the single largest group.

The Council has noted that data sets exist that can provide useful information about pedestrian fatalities, injuries and behaviors. However, the data comes in various formats and is not always generally accessible. This presentation was a way to show what data is available and whether the data sources are compatible with one another. Our goal in this exercise was to understand what is available and how it could be better integrated.

We hoped to determine:

1. Whether looking at individual cases provides us with potential interventions
2. How useful the case study presentation model is in terms of uncovering data gaps

We looked in depth at five cases and made the following observations.

Observations from Case Study Exercise

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| **Observations about the data** | **Gaps/Opportunities/Recommendations** |
| Data exists but it takes a lot of effort to gather it into one place  Missing: DSHS data due to security issues, not available for this exercise but could be helpful going forward  Medical records might also shed light on individual situations, but who has time? Would it help to construct the big picture? | Gap: substance abuse history, suicide ideation, homelessness  *Child Death Review* is an established protocol. If we follow this model can we construct better data on which to base interventions and prevent fatalities and serious injuries?  *Child Death Review* model brings all the relevant experts on a given focus, e.g. homeless, substance abuse, to look at each case and draw conclusions regarding predictive, preventive, surrounding services (i.e. all the social touchpoints) |
| Random, small numbers: hard to find risk factor. | Need exposure model to take these from small case study to larger impact  Missing context. For example, surrounding area that generates pedestrian activity (housing, bars, clinics, etc.) |
| There are data inconsistencies from one jurisdiction to another   * Counties have inconsistent HIPPA policies. Some provide a great deal of information, others give very little * Don’t have coded approach for witness statements. * If we code do we get the big picture but lose the deeper story? |  |
| In these cases, it appears that many *impaired pedestrians* are people who are already in the “system” due to substance abuse, mental health, law enforcement, disability/public assistance/food stamps | Data integration could help (PIO, Hospital data, SS data) |

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| Data from the Liquor and Cannabis Board (LCB) and insurance companies could be relevant. “Bad behavior” bars are an epi-center of social ills: fights, domestic violence, traffic safety. Ripe for predictive analytics. | Data from LCB and insurance companies could:   * Help identify problem bars using LCB citations and insurance ratings * Inform the use of predictive analytics |
| **Driver Characteristics** | **Gaps/Opportunities/Recommendations** |
| Drivers with checkered driving histories | DOL warning letter |
| Several drivers had some substances in their systems | Make involvement in a fatal or serious injury crash probable cause for getting a warrant for blood draw  Make blood warrants quicker |
| One driver admitted they looked down for a second (distracted driving) | Expanded distracted driver law might help |
| **Impaired Pedestrian Characteristics** | **Gaps/Opportunities/Recommendations** |
| Common factors   * Impaired * After dark * Wearing dark clothing * In the vicinity of pedestrian generators, e.g. bars, casinos, clinics, mobile home parks * Walking/wandering in street or along shoulder – most not trying to cross the street * Multiple points for intervention prior to crash. For example, in Case #3 – Casino, law enforcement, on public assistance, passing motorists shouting to “get out of the road,” but kept driving | *Friend intervention*: might be able to do something if they knew the danger  Law enforcement: what was the call that was more important than attending to the impaired pedestrian?  What can we learn from DSHS data? |
| Walking because they were impaired and felt it was safer than driving. We don’t have tools for “walking drunk” like we do for driving drunk. | Resurrect the Drunk in Public law? |
| **Road Characteristics** | **Gaps/Opportunities/Recommendations** |
| Minimal lighting | No current guidelines for lighting  Traffic volumes/pedestrian counts would help; identify areas for engineering improvements  Ped signals (HAWK) can help but how to get people to use them? |
| No crosswalk, minimal lighting  Underdeveloped transportation facilities for surrounding population/traffic. Roads/highways that have not kept up with the development occurring around them | Possible pedestrian emphasis area; improved engineering/traffic calming could help  There are many roads across the state like this. How to prioritize? What short term changes would help? |
| Casino along high speed road | 45 is an inappropriate speed near a high traffic, pedestrian generating facility  Lower speed limit, erect barriers |
| Crashes occurring near pedestrian generators   * Strip malls * Bars (over serving?) * Casinos * Clinics * Fast food restaurants * Convenience stores | Roads are underdeveloped for the amount of surrounding activity: schools, housing developments, other pedestrian generators  Create “bar zones” and “pedestrian zones” adjacent to pedestrian generators  Built environment solutions are more effective than artificially low speed limits  Need to give road design consideration adjacent to bars, casinos. |
| Most of these cases occurred in unincorporated areas | Are there more pedestrian crashes in unincorporated areas than incorporated? Rural vs. urban? |

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| **Opportunities for Public Education/Awareness** | **Gaps/Opportunities/Recommendations** |
| Metro alerts drivers to areas with known homeless, drug using, clinics | Increase public/driver awareness of pedestrian generators such as homeless encampments |
| Noticed a theme: blood alcohol alone may not indicate legal impairment but in several cases cannabis was also involved | Articulate the combined effects  More research on combined effects of MJ and alcohol. (WTSC report on both in crashes) |

The Council identified the following questions. This information is needed to help them formulate recommendations on improving pedestrian data and reducing fatalities and serious injuries:

What geo-coded pedestrian crash data is available now?

Where is crash data most consistent?

How do we start drawing conclusions/reach agreement on the problems that can be addressed?

How can we get to short term, actionable items?

What are the root causes? What is the common factor for pedestrian related fatalities? Speed, DUI, location (rural vs. urban), roadways (state routes, interstates, city/county roads)?

More consistent data capture at the scene. Use of checklists? State standards?

Capture of “non-traditional” data such as the connection between WSLCB violations and pedestrian crashes, overserving information, DUI arrests

Form a team to pull data from medical examiner/coroner’s office, including 1) medical history, 2) psych history, 3) addictions/abuse, 4) social services profile

How can we capture exposure data? How are others doing it? Exposure = how many people are walking and where

Can we get better quality speeding data?

Can we get socio economic status data (including homelessness)?

Can state collision form be modified to indicate the presence/absence of pedestrian fatalities? Believe we already track walking inside vs. outside roadway, but additional data would be useful.

Does any state agency install ADRs for pedestrians/bicyclists? Do any granting agencies fund ADRs? Can these be widespread?

Are homeless populations geocoded?

How does marijuana, coupled with alcohol, impact crash frequency? What can we communicate about the presence of both in fatal and serious crashes?

What data are we missing from what we have learned, and how do we obtain it?

Other potential data sources:

* Lab data
* D.O. acts type model for pedestrian for locations
* Data for each area by Target Zero locations/task forces
* Homeless/transient data with fatal crashes

Is there a way to break out data/info in a way that would identify differences in crash events for urban vs. rural setting, e.g. impaired walking more evident in rural settings? Are there other distinguishing factors?