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## DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

Safety Advisory 2007-01

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Notice of Safety Advisory; Safety in Yards; Behavior of Employees On or About Tracks; and Point Protection.

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SUMMARY: FRA is issuing Safety Advisory 2007-01, which addresses the safety of shoving or pushing movements in yards, including those involving remote control locomotives. This advisory also addresses the behavior of employees on or about tracks.

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SUPPLEMENTARY INFORMATION: Although the overall safety of railroad operations has improved in recent years, a recent fatal accident involving a carman struck by a remote control yard movement while he was backing a pickup truck onto an in-yard private railroad grade crossing (yard crossing) highlights the need to review current railroad procedures and practices.

Results of Preliminary Investigation

The following discussion of the circumstances surrounding a fatal accident that occurred on December 14, 2006, is based on FRA's preliminary investigation. The accident is still under investigation by FRA and local authorities. The causes and contributing factors, if any, have not yet been established; therefore, nothing in this Safety Advisory should be construed as placing blame or responsibility for the accident on the acts or omissions of any person or entity.

The fatal accident occurred in Manlius, New York, a suburb of Syracuse, in CSX Transportation, Inc.'s (CSX) DeWitt Yard at about 5:25 p.m. on December 14, 2006. The

victim was a 54-year-old carman with about 30 years of railroad service. While backing a pickup truck onto a yard crossing, he was struck by a yard movement of railroad cars shoved by a remote control locomotive. The remote control operator (RCO) aligned a track switch, initiated the yard movement by remote control, and was driven to the East End Yardmasters Tower by another CSX employee while the yard movement was underway.

The RCO stated that as he was riding to the East End Yardmasters Tower, he made a visual determination that the track (including the track at the two yard crossings over which the movement traversed) was clear of equipment or other obstructions. The yard movement was not conducted in an activated remote control zone. During the approximately \1/4\-mile shoving movement, the leading end of the movement was not under continuous observation by the RCO. The route traversed included both the yard crossing on which the accident occurred and a second, paved yard crossing.

The leading end of the yard movement, which is the end that struck the carman's pickup truck, consisted of six empty flat cars. Due to its low profile, the approach of an empty flat car is less perceptible than the approach of other rolling stock, e.g., box car, tank car, locomotive. This was exacerbated by darkness, as the sun had set approximately 1 hour before the accident.

Upon impact, the carman's truck was shoved for about 444 feet whereupon it flipped onto its roof and was additionally shoved approximately 490 feet. Immediately after the accident, the truck was observed with its backup lights illuminated and its backup alarm sounding, indicating that the carman had backed onto the crossing ahead of the yard movement.

The RCO stated that he stopped the yard movement when he noticed a strange white light at the leading end of the yard movement and heard a radio transmission to stop the yard movement. The preliminary investigation disclosed that upon impact, the carman in the pickup truck transmitted his urgent plea on the mechanical department radio channel to stop the movement. That transmission was heard by the yardmaster because he could monitor the mechanical department channel in the yard office. Within seconds, the yardmaster observed the carman's truck being shoved and radioed the RCO to stop. Because the carman and the RCO were utilizing different radio channels, the carman was unable to contact the RCO directly. The yard movement finally came to rest about 1,490 feet from where the movement was initiated and 934 feet from where it struck the carman's truck. The autopsy determined that the cause of death was due to injuries sustained when the truck overturned while being shoved by the yard movement. Post-accident testing of the carman's urine specimen revealed the presence of marijuana metabolite (THCA) at low levels. Neither the parent drug (THC) nor the marijuana metabolite was detected in the blood at the established cutoff point. Since the marijuana metabolite was not active and the parent drug was not reported in the blood, these findings do not provide scientific evidence that would support any conclusion regarding possible impairment of the carman's faculties. This is particularly the case since death occurred shortly after the impact, and marijuana constituents remain stable in these fluids for long periods after metabolism ceases.

## Safety Issues

CSX's General and Operating Equipment Rule R15 (published in CSX System Bulletin 001 of October 1, 2006, under Instructions Governing Remote Control Locomotive Operation) states, in relevant part, that [P]oint protection must be provided when cars, platform or engines are being moved and conditions require. A crewmember must take a position on the lead equipment to see that the track ahead is clear, or be ahead of the movement. When an

RCO operator is providing point protection, that operator should be the primary operator when practicable.

CSX rules do not define the term ``point protection." Although the RCO was ahead of the movement as permitted by CSX rule, he did not observe the collision and initiated a brake application only after hearing a radio transmission from the yardmaster.

The preliminary investigation indicates that the RCO controlled the yard movement while riding in a moving motor vehicle. CSX General and Operating Equipment Rule R8 states, in relevant part, that ``[an] RCL [remote control locomotive] crew member will not operate an RCL \* \* \* while riding in a moving motor vehicle or other machinery that is not connected to their consist." This rule goes further than FRA's published guidelines for the operation of remote control locomotives, which states, in relevant part: ``[W]hen operating an RCL, the RCO should not operate any other type of machinery [66 FR 10340, 10344 (Feb. 14, 2001) (Notice of Safety Advisory 2001-01)]." Both CSX Rule R8 and FRA guidelines were intended to address the lack of situational awareness that a person may experience when `multitasking"--in this case, focusing on a moving train while at the same time operating or riding in a moving vehicle.

Although Federal regulations do not currently prohibit shoving movements conducted in the manner described by the preliminary findings of this accident, FRA is contemplating the regulation of shoving movements as addressed in a recently published FRA notice of proposed rulemaking (NPRM), "Railroad Operating Rules: Program of Operational Tests and Inspections; Railroad Operating Practices: Handling Equipment, Switches and Derails [71 FR 60372, 60410 (October 12, 2006)]." In the NPRM, FRA stated that it proposes:

A requirement that the employee providing point protection visually determine, for the duration of the shoving or pushing movement, that the track is clear within the range of vision for the complete distance to be shoved or pushed. Shoving accidents often occur because a train crew makes a shoving movement without determining that the track is clear in the direction of movement. This proposed paragraph would address this problem by requiring an operating rule that keeps a qualified employee observing the track to make sure it is clear and remains clear [71 FR 60393].

In this instance, the RCO apparently made an initial determination that the track was clear, but was not in a position to determine that the track would remain clear of conflicting mechanical department vehicles. (See 71 FR at 60409 defining ``track is clear.") Although FRA has proposed requirements for shoving movements, it has not made any decisions as to the contents of a final rule in that proceeding, and thus the proposal is not now, and may not in the future become, a regulatory requirement. Railroads, however, are encouraged to consider FRA's proposed rule and this incident as they review their operating rules.

The investigation of this accident also raised questions regarding the visibility of the rail car leading the shoving movement. As stated earlier, the lead car was a low-profile, empty flat car followed by five more empty flat cars. The first freight car of significant height was the seventh car from the lead, a box car. It is possible that the carman did not see the low-profile cars in the darkness. Although FRA does have regulations pertaining to reflectorization of freight cars, there are no Federal rules regarding illumination within rail yards, at yard crossings, or on the leading point of a movement.

The following CSX rules may apply to this accident:

CSX Safe Way, Effective January 1, 2006 at GS-10. On or About Tracks; When working on or about tracks: \* \* \* Be alert for and keep clear of the movement of cars, locomotives, or equipment at any time, in either direction, on any track. \* \* \* Stop and look in both directions before making any of the following movements: Fouling or crossing a track.

SJP C-177 (Rev 3/99) Safe Procedure for Backing Vehicle Driver Only:

Step 4. Always look behind you before backing. If you are not sure get out and look again.

Step 5. Avoid backing when possible, pull thru if you can, or make a circle wide enough.

Operating rule 103: When cars are shoved and conditions require, a trainman must take a conspicuous position on the leading car. At night, the trainman must display a white light.

## Recommended Action

In light of the above discussion and in an effort to maintain safety in the Nation's rail yards, FRA recommends that railroads:

- (1) Assess their current rules addressing safety at yard crossings, including rules governing shoving and pushing movements and backing motor vehicles;
- (2) Review, or amend as necessary, their point protection rules to clarify that the person protecting the point visually determine, for the duration of the shoving or pushing movement, that the track is clear either within the person's range of vision or for the complete distance the equipment is to be shoved or pushed, or that other safeguards are observed to prevent critical incidents involving shoving movements. FRA notes that continuous observation cannot be accomplished if the person is also attempting to accomplish other tasks that cause the person to divert attention from providing point protection;
  - (3) Review their point protection rules and their importance with all relevant employees;
- (4) Review their current rules pertaining to employee behavior on or about tracks with particular emphasis in yards with all relevant employees;
- (5) Address the ability of employees to call for assistance in emergency situations through the use of common emergency radio frequencies, or by other means; and
- (6) Assess the conspicuity of flat cars and other equipment with low profiles and consider measures available to increase their visibility when they are the lead car in a shoving movement, especially at yard crossings.

Failure of industry members to take action consistent with the preceding recommendations or to take other actions to ensure yard safety may result in FRA pursuing other corrective measures under its rail safety authority. FRA may modify this Safety Advisory 2007-01, issue additional safety advisories, or take other appropriate action necessary to ensure the highest level of safety on the Nation's railroads.

Issued in Washington, DC, on January 11, 2007. Joseph H. Boardman, Administrator.

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