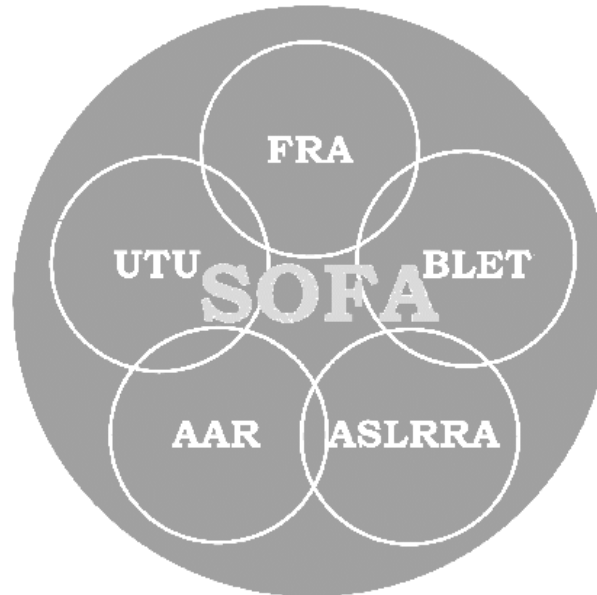


(Please Post Immediately)

Zero Out Switching Fatalities

The average age of the employees involved in April switching fatalities is 51.9 years old.
page 7



Special Switching Hazards
pages 16-17

Severe Injuries up in 2004
page 12

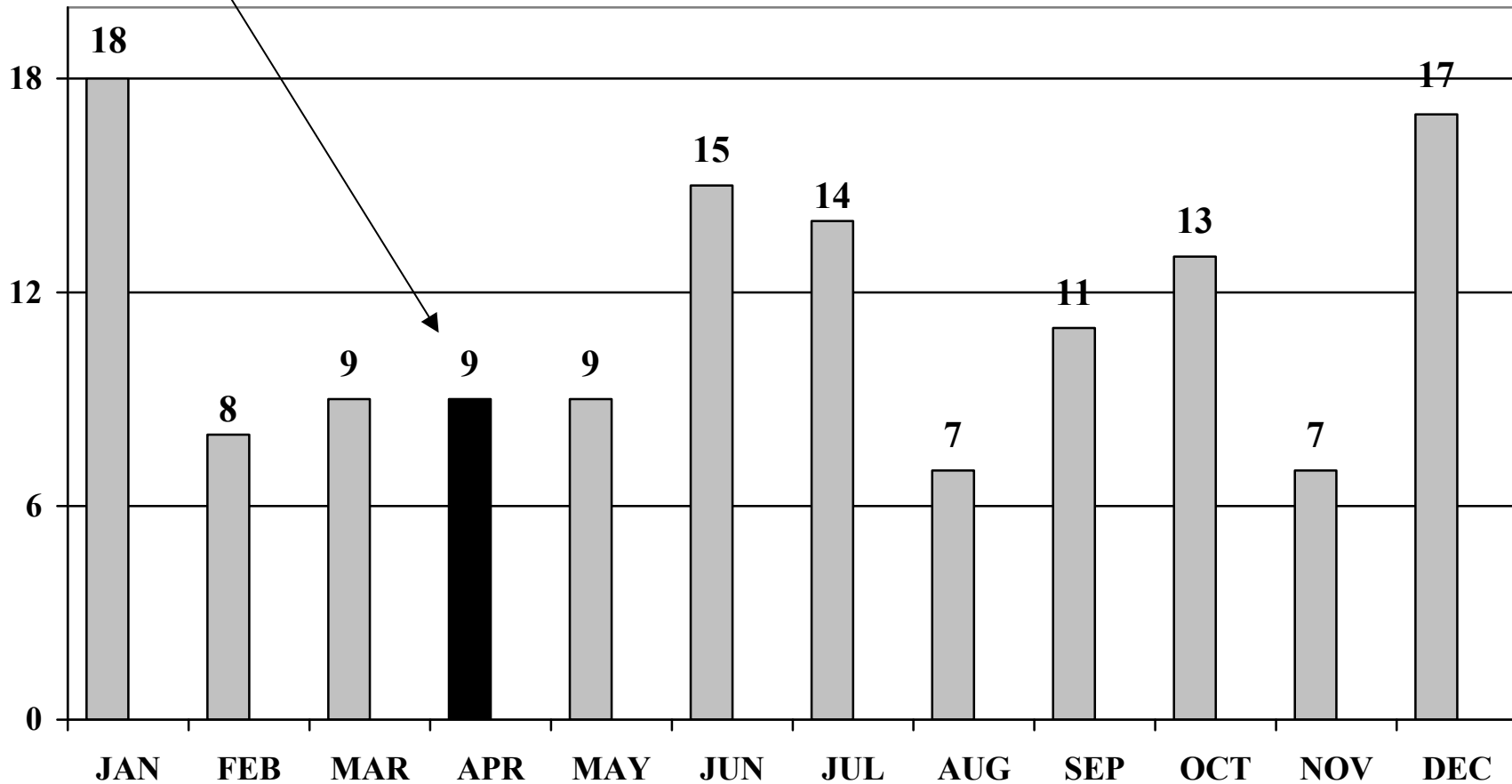
April 2005 UPDATE

- **7 of 9 April Switching Fatalities involved Special Switching Hazards.**
- **2 of 9 April Switching Fatalities involved Recommendation 3:**

“At the beginning of each tour of duty, all crew members will meet and discuss all safety matters and work to be accomplished. Additional briefings will be held any time work changes are made and when necessary to protect their safety during their performance of service.” – Findings and Recommendations of the SOFA Working Group, October 1999

April 2005 Overview

9 of 137 Switching Fatalities since 1992 Occurred in April

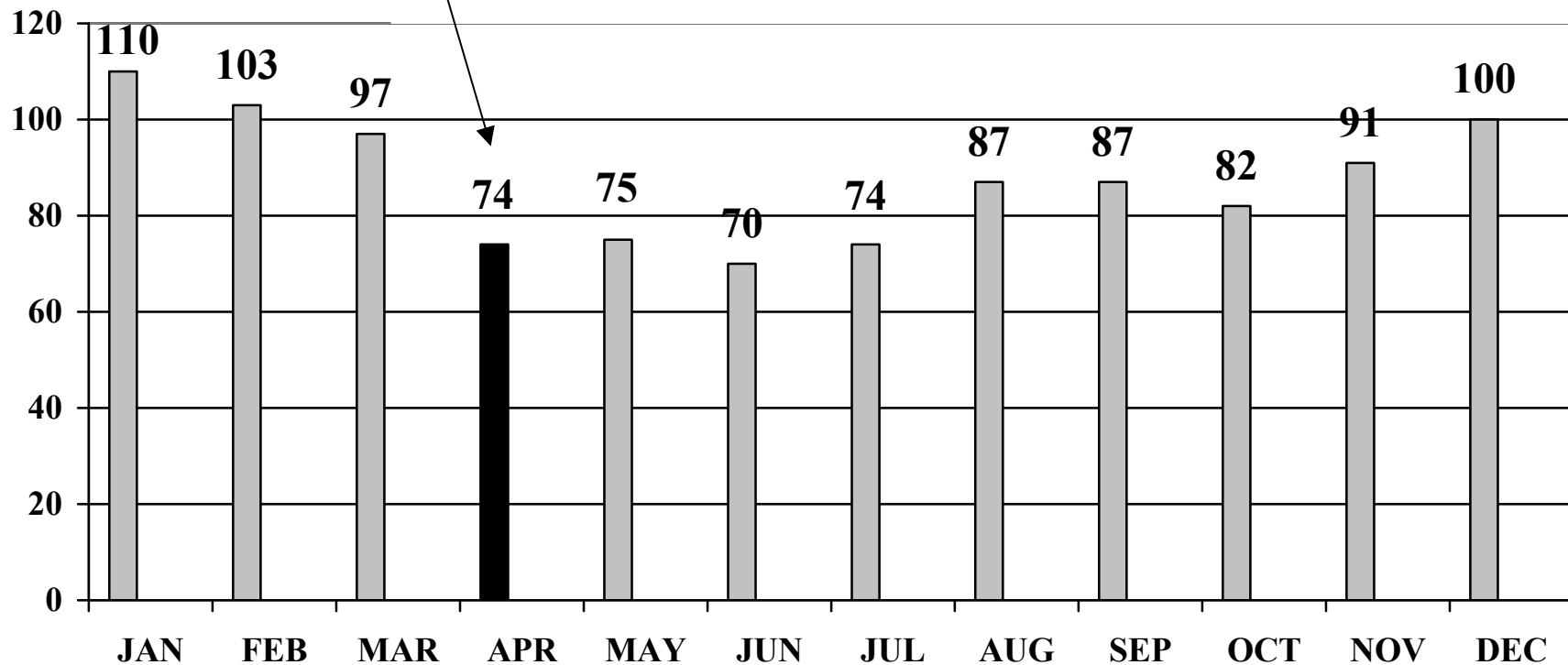


10.3 switching fatalities occur each year on average

74 SOFA-defined Severe Injuries (including amputations)* in April (January 1997 to December 2004)

* *Severe Injuries* were defined by the SOFA Working Group as (1) potentially life threatening; (2) high likelihood of permanent loss of function, permanent occupational limitation, or other permanent disability; (3) likely to result in significant work restrictions; and (4) result from a high-energy impact to the human body. 'Severe Injuries' include amputation, dislocation of the neck, loss of eye, electric shock or burn, and fracture to any bone except the lower arm, fingers, foot, and toes, See *Severe Injuries to Train and Engine Service Employees: Data Description and Injury Characteristics*. July 2001. This report may be found on the FRA's website.

74 SOFA-defined Severe Injuries in April



1,050 Severe Injuries occurred from January 1997 through December 2004**

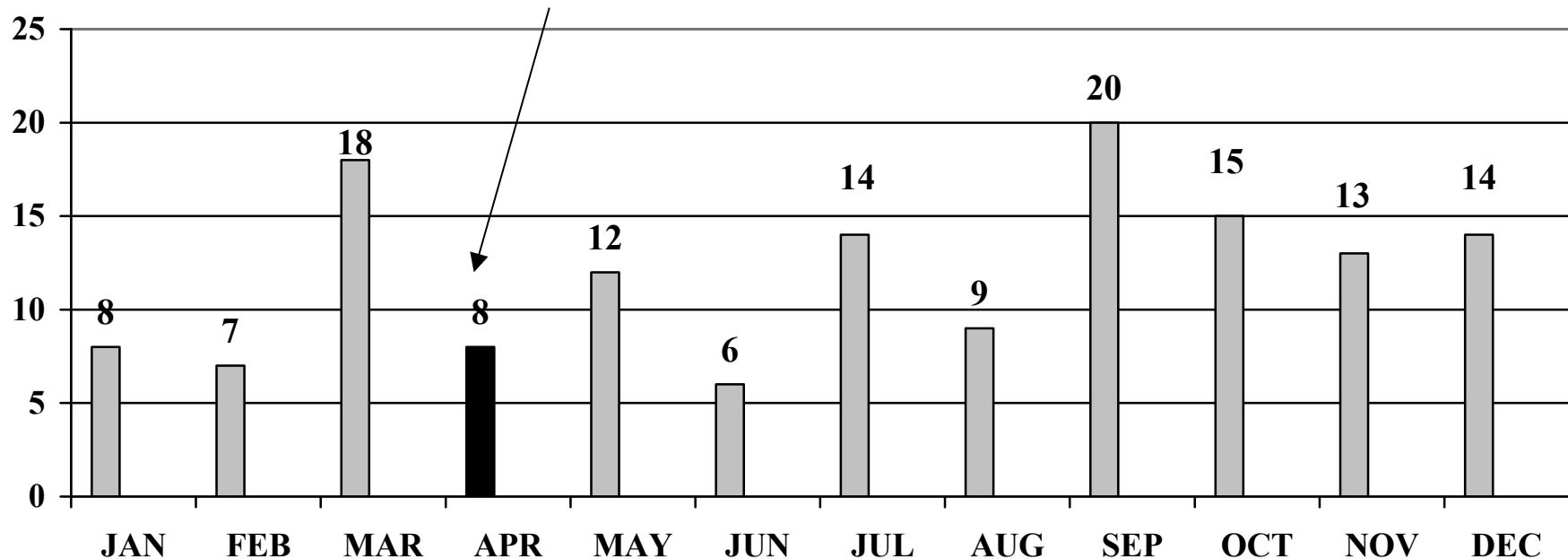
** Latest month available from the Federal Railroad Administration's electronic files

132.4 Severe Injuries occur each year on average

8 Amputations (a type of Severe Injury) in April (January 1997 to December 2004)

- Amputations are a type of SOFA-defined Severe Injury and are counted in Severe Injuries.
- Amputations are displayed separately because of the extreme nature of trauma to employees engaged in switching operations, and the potential for permanent occupational limitation.

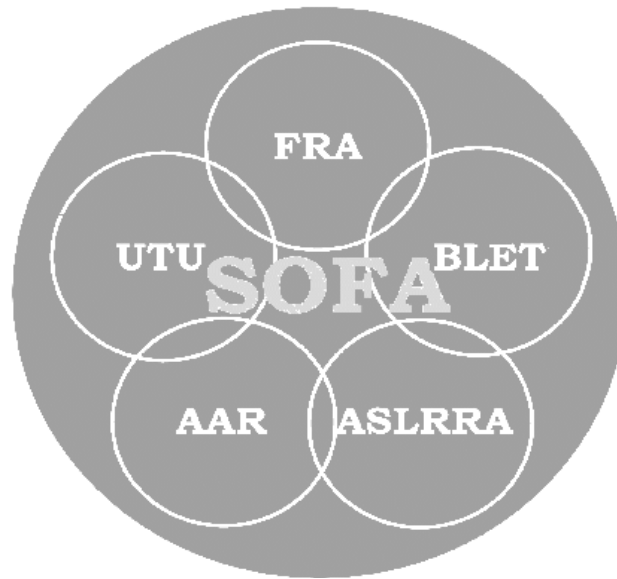
8 amputations occurred in April since 1997



144 amputations occurred from January 1997 through December 2004*

* Latest month available from the Federal Railroad Administration's electronic files

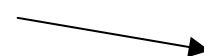
18.1 amputations occur each year on average



Switching Fatalities

9 April Switching Fatalities, January 1992 through December 2004

Read more about these fatalities and how such events can be prevented in
Findings and Recommendations of the SOFA: August 2004 Update Working Group



| # | Date | RR | Location | Age | Service (yrs) | Employee's Job | Employee Act | Employee Location | Fatal Event | SOFA Recommendation | Special Switching Hazard |
|---|---------|------|---------------|-----|---------------|----------------|----------------------------|-------------------|-----------------------|-------------------------|---------------------------|
| 1 | 4/09/92 | ATSF | Cheto, AZ | 54 | 13 | road engineer | opening/closing angle cock | on ground | struck by equipment | ---- | Free-Rolling Railcars |
| 2 | 4/13/93 | CSX | Dwale, KY | 44 | 16 | road brakeman | walking | on track | struck by equipment | ---- | Struck by Mainline Trains |
| 3 | 4/12/94 | SP | Houston, TX | 62 | 37 | yard conductor | riding | on side of car | struck against object | ---- | Close Clearance |
| 4 | 4/06/95 | WC | Argoe, WI | 45 | 7 | road conductor | riding | on end of car | collision | ---- | Unsecured Cars |
| 5 | 4/02/99 | DME | Waseca, MN | 54 | 21 | yard brakeman | coupling air hose | between cars/loco | struck by equipment | Recommendation 3 | ---- |
| 6 | 4/09/99 | UP | Richland, WA | 58 | 39 | road conductor | standing | on loco | collision | ---- | Equipment |
| 7 | 4/21/00 | BNSF | Galesburg, IL | 60 | 32 | yard conductor | standing | beside track | struck by equipment | ---- | Free-Rolling Railcars |
| 8 | 4/08/01 | BNSF | Clark, OK | 35 | 3.8 | road conductor | riding | on side of car | collision | ---- | Miscellaneous |
| 9 | 4/11/03 | UP | Pocatello, ID | 55 | 23 | road conductor | riding | on end of car | derailment | Recommendation 3 | ---- |

The average age of the employees was 51.9 years; average length of service was 21.3 years.

Narratives of 9 April Switching Fatalities

SOFA Recommendation and/or Special Switching Hazard

1 April 09, 1992 – ATSF – Cheto, AZ

Free-Rolling Railcars

A three-person crew was called to operate a road local and arrived at a location where an eight-car drop would be necessary. After a job briefing, the engineer was at the throttle, the conductor at the switch and the brakeman was riding the first car of the drop, “A” end. The engineer began to pull, the brakeman lifted the pin, the engineer accelerated the locomotive beyond the switch, the conductor got the switch and the cars began free rolling into the yard. However, the speed of the movement would not allow the brakeman to safely dismount and, just before impact with another cut of cars, the brakeman attempted to dismount from the car he was riding and was killed as the cars rolled over him.

2 April 13, 1993 – CSX - Dwale, KY

Struck by Mainline Trains

A three-person crew reported for duty and was transported to a location where they took control of a mainline train. En-route, their work included swapping rear end marking devices. The brakeman apparently became confused, stepped into and began walking within the gauge of the main track, and was struck in the back by a passing mainline train.

3 April 12, 1994 – SP – Houston, TX

Close Clearance

A three-person switching crew was in the process of switching out the car repair shop. The foreman had taken a position on the trailing end of the third leading car as the move was being shoved into a track having a close clearance condition that involved a protective grate that covered a winch. The foreman was knocked off the car by the covering, fell in front of the leading wheels of the fourth leading car, and was later pronounced dead at the hospital.

4 April 06, 1995 – WC – Argoe, WI

Unsecured Cars

A two-person crew was switching at a siding in single-track territory. The conductor left a portion of his train on the mainline and went into the siding with a cut of cars. While in on the siding, the cars left on the mainline and, as post accident investigation revealed, had been left with the air “bottled”, rolled away. The crew chased the runaway cars with the conductor riding the leading end of the lead car and the engineer, 23 cars away, shoving as directed by radio commands from the conductor. The shove move struck the runaway cars and the conductor was crushed to death as a result of the collision.

Narratives of 9 March Switching Fatalities (continued)

SOFA Recommendation and/or Special Switching Hazards

5 April 02, 1999 – DME – Waseca, MN

Recommendation 3

A three-person yard switching crew was switching and the conductor was pulling pins while the brakeman was taking orders from him and working the yard tracks during a flat switching operation. The conductor cut off three cars that rolled into other cars on the track. The brakeman was run over by these cars.

6 April 09, 1999 – UP – Richland, WA

Equipment

A three-person road switcher was in the process of dropping a car into a track. However, the locomotive was fouling the track the car was to enter. The brakeman, realizing this, jumped from the trailing end of the car and ran to the leading end to try and stop the car. The conductor, who was standing near the fouling corner of the locomotive, started up the stairwell of the locomotive when he realized what was happening. However, the stairwell was obstructed with a metal rod that had been welded into place and prevented the conductor an escape route. He was subsequently crushed between the striking car and the metal rod.

7 April 21, 2000 – BNSF – Galesburg, IL

Free-Rolling Railcars

A three-person switching crew was in the process of hauling cars over the hump and the foreman of the crew was observing the move from between his track and another track that was being used by another yard job. The foreman was killed when he fouled and then was struck by a free rolling car on the adjacent track.

8 April 08, 2001 – BNSF – Clark, OK

Miscellaneous

The conductor of a road switcher pulled his train into a yard, got off, made a cut behind three cars and told the engineer to pull ahead to clear a crossover switch he intended to use. After getting the crossover, he mounted the leading end of the move and told the engineer to come back seven cars. Three car lengths later, the movement passed through one end of another crossover switch in reverse position and diverted the movement into the side of a standing cut of cars crushing the conductor to death.

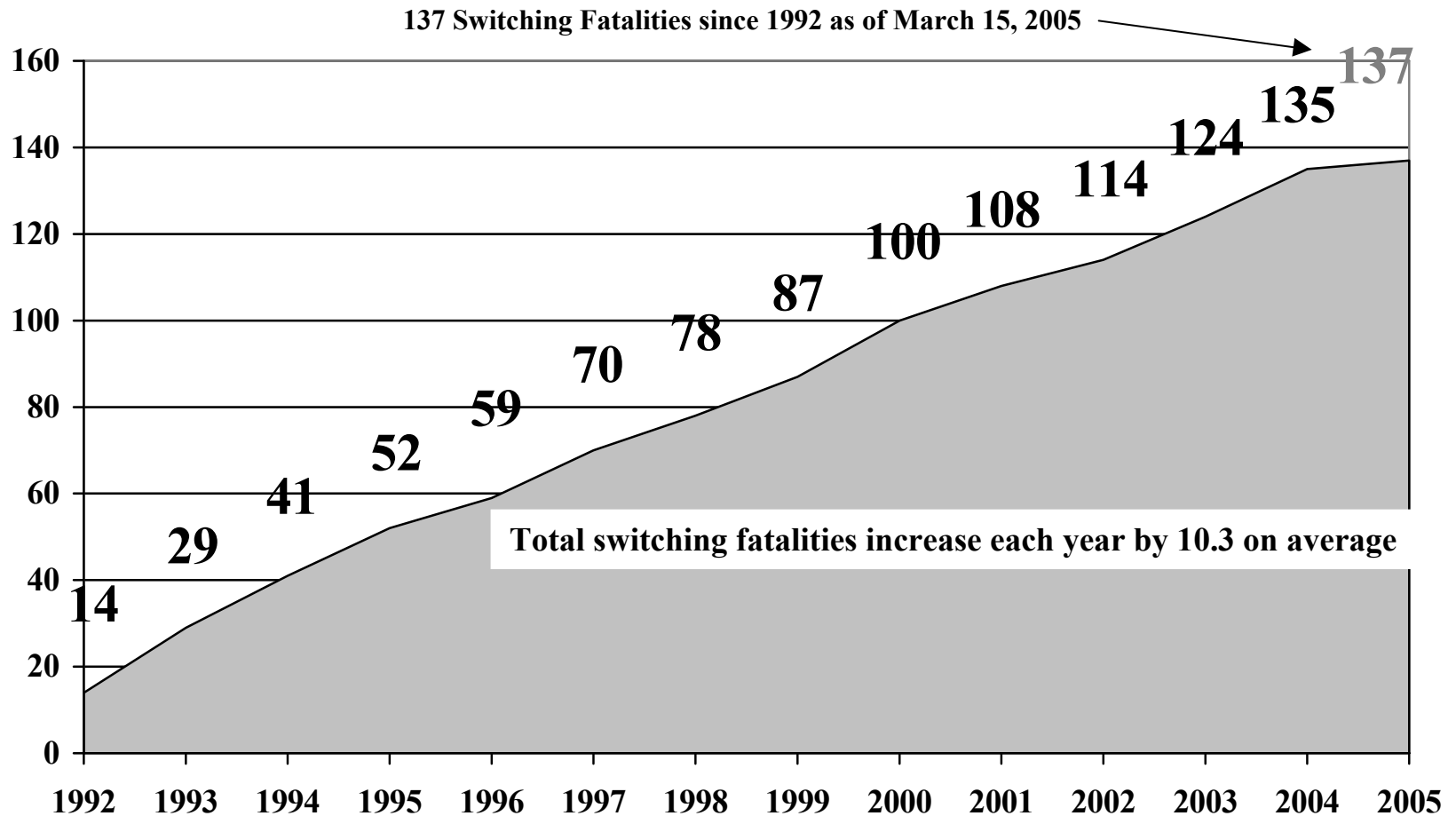
9 April 11, 2003 – UP – Pocatello, ID

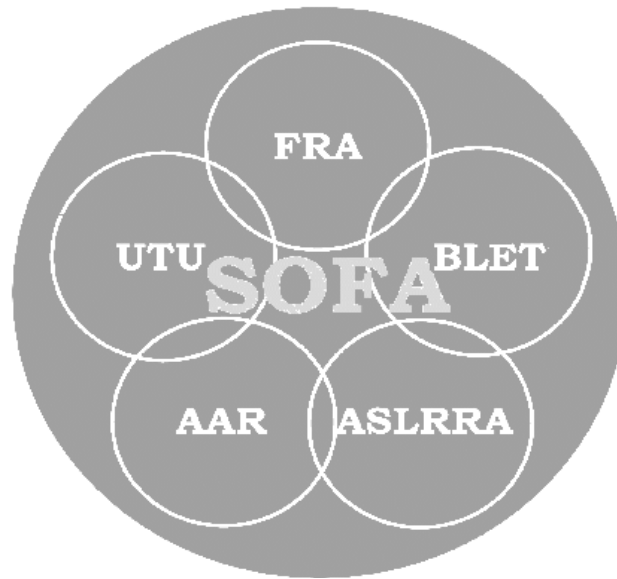
Recommendation 3

A road conductor was riding the point of a 122-car shove down a track that was partially out of service. The out of service portion was marked by a red flag and derail. The crew was not able to stop the movement before the car being ridden by the conductor went over the derail, landed on its side and crushed the conductor to death.

2 Switching Fatalities in 2005 through March 15

1. **JAN 10**...Union Pacific (UP) conductor, with 32 years of service, was struck by a mainline train when he stepped out from between the cars of his train in Buena Vista, AR.
2. **JAN 26**...Pacific Harbor Line (PHL) conductor was struck by his train at 5:30 pm while lining a switch at Los Angeles, CA.





SOFA-defined Severe Injuries

SOFA-defined Severe Injuries ¹

Injuries

Amputations ²

January 1992 to December 2004

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|------------------|------------|------------|------------|------------|------------|------------|------------|------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| JAN | 11 | 13 | 16 | 15 | 21 | 12 | 11 | 11 | 1 | 0 | 2 | 1 | 0 | 0 | 2 | 2 |
| FEB | 17 | 15 | 9 | 9 | 9 | 13 | 17 | 14 | 0 | 1 | 0 | 1 | 0 | 2 | 1 | 2 |
| MAR | 14 | 12 | 17 | 11 | 10 | 10 | 13 | 10 | 3 | 4 | 3 | 2 | 1 | 1 | 3 | 1 |
| APR | 8 | 10 | 6 | 10 | 12 | 6 | 9 | 13 | 1 | 2 | 0 | 1 | 2 | 0 | 1 | 1 |
| MAY | 6 | 12 | 8 | 8 | 12 | 14 | 9 | 6 | 1 | 2 | 3 | 0 | 2 | 2 | 2 | 0 |
| JUN | 9 | 10 | 8 | 11 | 8 | 5 | 10 | 9 | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 1 |
| JUL | 9 | 14 | 10 | 8 | 10 | 7 | 6 | 10 | 1 | 5 | 1 | 0 | 4 | 0 | 1 | 2 |
| AUG | 13 | 10 | 11 | 14 | 8 | 10 | 7 | 14 | 1 | 0 | 1 | 4 | 0 | 1 | 0 | 2 |
| SEP | 10 | 11 | 15 | 10 | 20 | 12 | 5 | 4 | 2 | 4 | 3 | 2 | 5 | 4 | 0 | 0 |
| OCT | 12 | 12 | 16 | 10 | 5 | 11 | 9 | 7 | 2 | 5 | 2 | 2 | 0 | 0 | 2 | 2 |
| NOV | 12 | 9 | 12 | 11 | 13 | 14 | 10 | 10 | 2 | 2 | 2 | 2 | 3 | 0 | 1 | 1 |
| DEC ³ | 18 | 9 | 7 | 22 | 12 | 9 | 8 | 15 | 4 | 1 | 0 | 4 | 1 | 1 | 2 | 1 |
| totals | 139 | 137 | 135 | 139 | 140 | 123 | 114 | 123 | 20 | 27 | 18 | 19 | 19 | 11 | 15 | 15 |

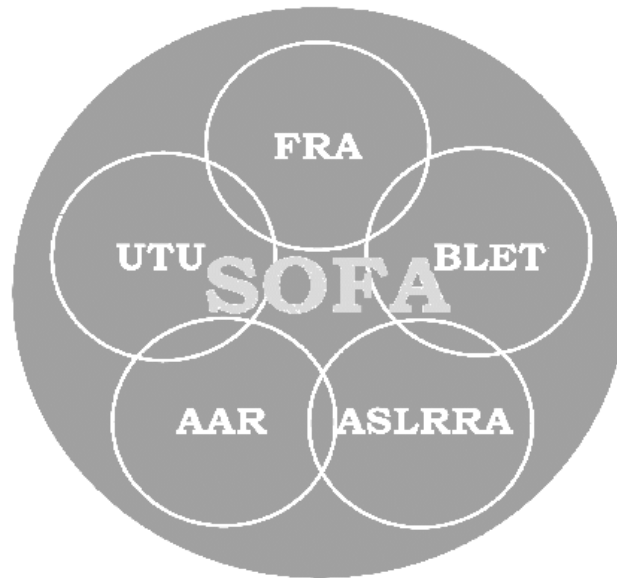
123 Severe Injuries in 2004. Up 8 percent from 2003. December 2004, with 15 Severe Injuries, was the third highest December since 1997.

15 Amputations in 2004. Equal to the number in 2003.

¹ *Severe Injuries* were defined by the SOFA Working Group as (1) potentially life threatening; (2) high likelihood of permanent loss of function, permanent occupational limitation, or other permanent disability; (3) likely to result in significant work restrictions; and (4) result from a high-energy impact to the human body. 'Severe Injuries' include amputation, dislocation of the neck, loss of eye, electric shock or burn, and fracture to any bone except the lower arm, fingers, foot, and toes, See *Severe Injuries to Train and Engine Service Employees: Data Description and Injury Characteristics*. July 2001. This report may be found on the FRA's website.

² Amputations are a type of SOFA-defined Severe Injury and are counted in 'Injuries'. Amputations are broken out separately because of the extreme nature of trauma to employees engaged in switching operations, and the potential for permanent occupational limitation.

³ December is the latest month of Severe Injuries available from the Federal Railroad Administration's electronic files.



Prevention

Two of Nine April Switching Fatalities Involved Recommendation 3:

Waseca, MN, and Pocatello, ID

Recommendation 3

At the beginning of each tour of duty, all crew members will meet and discuss all safety matters and work to be accomplished. Additional briefings will be held any time work changes are made and when necessary to protect their safety during their performance of service.

Lifesaver 3

Discuss safety at the beginning of a job or when a project changes.

Discussion 3

Safe switching operations require teamwork and accountability among all crew members. Each crew member takes responsibility for their own and their fellow crew member's safety. Team work begins with a detailed, effective job briefing, but includes continued updates to all crew members describing the current state of each move as it is executed.

In its recent report,¹ the SOFA Working Group recommended:

- Expand job briefings (Operating Recommendation 3) to include:
 - emphasis of dangers of equipment left fouling
 - warnings to other crews when placing oversized cars on tracks adjacent to their work
 - discussions of risks of passing trains when working near mainline

¹ *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. p. 50

Fourteen Fatalities Involving Recommendation 3, January 1992 to December 2004

| # | RR | Date | Location | # | RR | Date | Location |
|---|-----|----------|----------------------|----|------|----------|-----------------|
| 1 | GBW | 07/24/92 | Wisconsin Rapids, WI | 8 | NS | 03/02/95 | Aiken, SC |
| 2 | IC | 06/07/93 | Fulton, KY | 9 | CR | 01/12/99 | Port Newark, NJ |
| 3 | SP | 08/11/93 | Tracy, CA | 10 | DME | 04/02/99 | Waseca, MN |
| 4 | GC | 11/13/93 | Macon, GA | 11 | UP | 10/15/00 | Houston, TX |
| 5 | SOU | 12/05/93 | Atlanta, GA | 12 | NS | 01/11/01 | South Fork, PA |
| 6 | CR | 11/15/94 | Painted Post, NY | 13 | BNSF | 06/16/02 | Memphis, TN |
| 7 | CR | 02/17/95 | St. James, OH | 14 | UP | 04/11/03 | Pocatello, ID |

The following material on Recommendation 3 is taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. p. 51-52. Pages 92 to 103 of this report contain examples of job briefing information.

It was apparent to the SWG [SOFA Working Group] that many of the diverse events and occurrences that lead to the death of employees may have been mitigated through effective “job safety briefing.” You can never communicate too effectively. It became apparent to the SWG that providing a minimum suggested content for an initial job safety briefing should be made available. It was also evident to the SWG that the perception of “work changes” is very qualitative and should be addressed in specific language that is understandable and comprehensible to all crew members. Job Safety Briefing instructions for *various* carriers are available for review in Appendix F.

All crew members should receive training in the art of job safety briefings. The initial job safety briefing should provide detailed and specific information on all relevant activities to be performed. The training should help necessitate sufficient conversation and review between every crew member to make everyone feel comfortable about the service to be performed. When practical, a supervisor or other knowledgeable employee should be present during the entire job safety briefing and take part in it when appropriate. Every concern should be addressed to the satisfaction of each crew member. Crew members should engage in active communications sufficient to establish their mutual understanding and safely perform the service required. Successful communication among all parties is essential.

Any work changes or developments that may impact safety should be immediately addressed to everyone’s satisfaction. Any crew member observing a safety concern should safely stop all activity and thoroughly review the concern with every other crew member. Job safety briefings should offer a comfortable environment for fellow employees to discuss yard and industry switching issues where questions or concerns may exist. Crew members should be afforded the opportunity to resolve any yard and/or industry switching issues. They should seek the advice of knowledgeable and experienced crew members, or proper authority if necessary. No action should be taken until a solution is reached and then communicated to all concerned.

Seven of Nine April Switching Fatalities Involved Special Switching Hazards:

- **Free-Rolling Railcars: Cheto, AZ in 1992 and Galesburg, IL in 2002**
- **Struck by Mainline Trains: Dwale, KY in 1993**
- **Close Clearance: Houston, TX in 1994**
- **Unsecured Cars: Argoe, WI in 1995**
- **Equipment Defects: Richland, WA in 1999**
- **Miscellaneous: Clark, OK in 2001(Crossover switch in reverse position.)**

Recognizing Special Switching Hazards

“In addition to the Five Operating Recommendations, the SWG (SOFA Working Group) wants to make those engaged in switching operations aware of Special Switching Hazards. In its review of each of the 124 fatalities, the SWG identified a number of fatalities involving close clearances (10 fatalities), being struck by mainline trains (8 fatalities), and occurring during shove movements (61 fatalities). The number of fatalities involving close clearance and being struck by mainline trains would be greater if those classified both as a Special Switching Hazard and an Operating Recommendation were included in these fatality counts.” - from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. p. xiv.

List of Special Switching Hazards Identified by SOFA Working Group...

- Close Clearances*
- Free Rolling Railcars
- Exposure to Mainline Trains
- Tripping, Slipping, or Falling Exposures
- Adverse Environmental Conditions
- Shoving Movements
- Unsecured Cars
- Unexpected Movement of Cars
- Equipment Defects
- Motor Vehicles or Loading Devices
- Drugs and Alcohol

To achieve the Zero Switching Fatality Goal...

Special Switching Hazards must be recognized

* The SOFA Working Group has broadened the traditional definition of ‘close clearances’ to include situations “When an employee is passing, or being passed, by an object or equipment and the conditions are such that there is not enough room for the employee to avoid being struck.” From *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. p. 48-50.