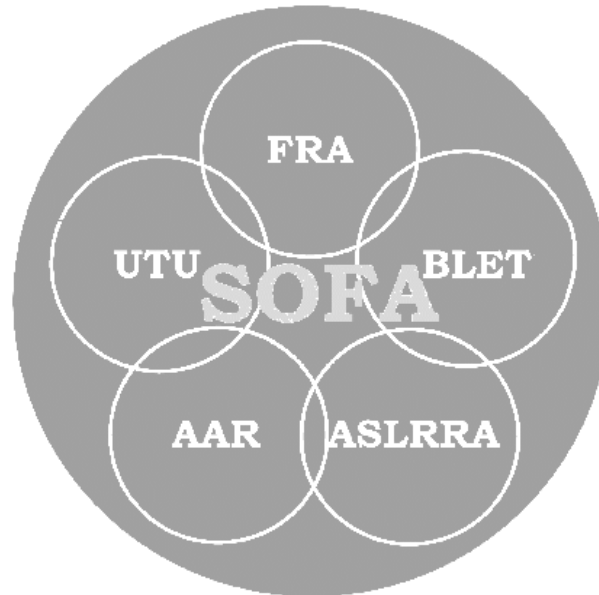


(Please Post Immediately)

Adopt the Zero Switching Fatality Goal



**A recent roll-by/
struck-by-mainline-train
fatality on January 10, 2005
at Buena Vista, Arkansas
may indicate a trend.**

FEBRUARY 2005 UPDATE

February ~ eight switching fatalities since 1992

February ~ the second highest month for Severe Injuries

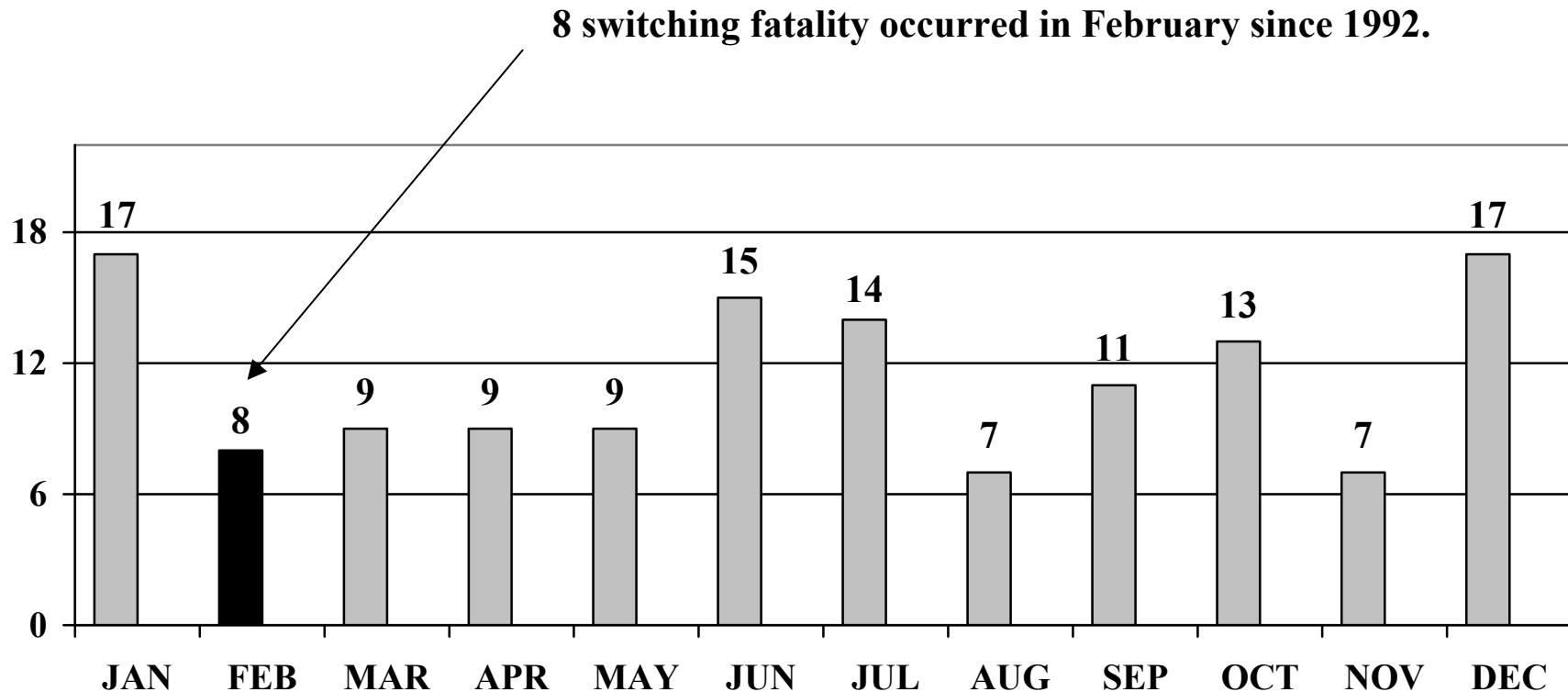
In 2003, three February fatalities occurred within 7 days of each other:

Flat Rock, MI, Feb. 11 (Tuesday) Syracuse, NY, Feb. 16 (Sunday) Cheektowaga, NY, Feb. 18 (Tuesday)

February 2005 Overview

8 Switching Fatalities in February Since 1992

There is always risk to employees engaged in switching operations. Since 1992, 136 switching fatalities have occurred through January 10, 2005. Some months had more fatalities ~ but no month is fatality free. On average, 10.3 fatalities occur each year.



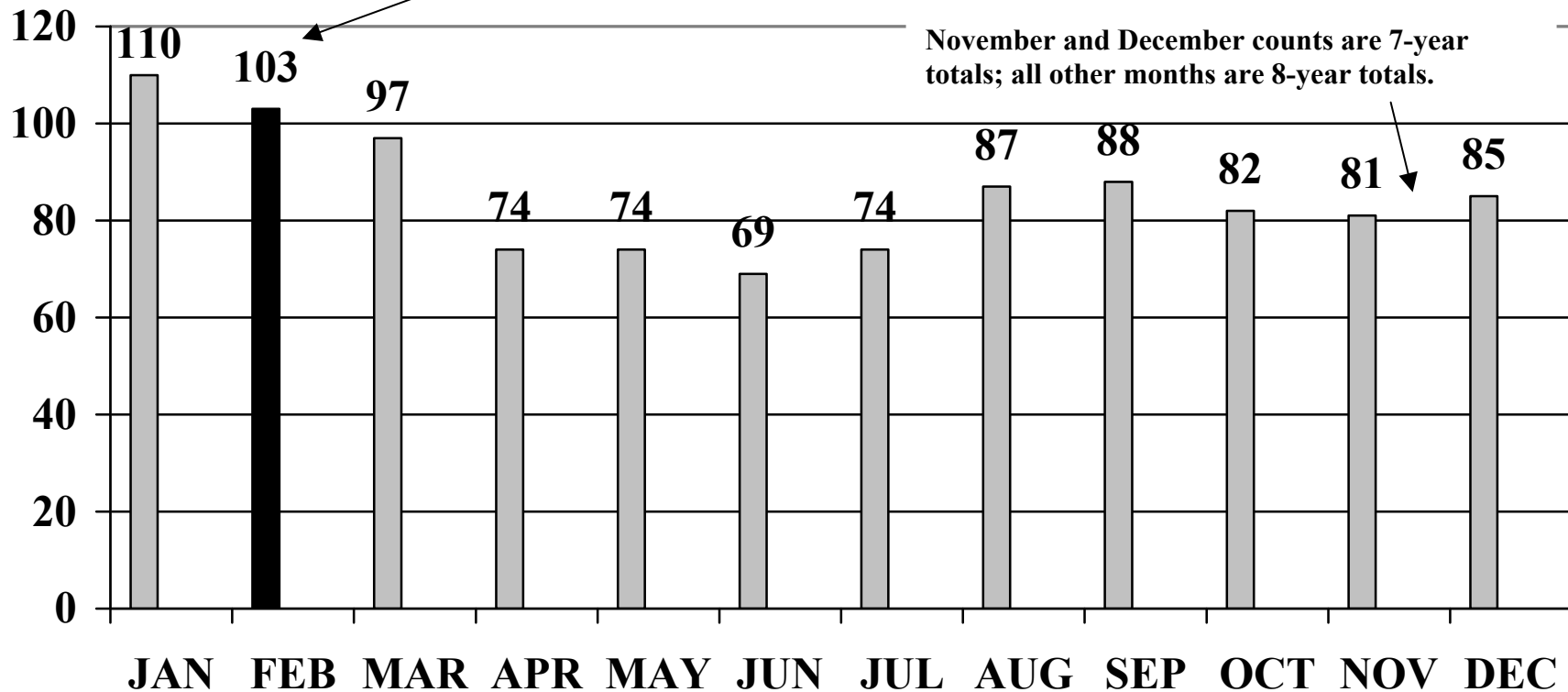
136 switching fatalities occurred since 1992 (through January 10, 2005)

10.3 switching fatalities occur on average each year

103 SOFA-defined Severe Injuries (including amputations)* in February (January 1997 to October 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.

February is the second highest month for SOFA-defined Severe Injuries.



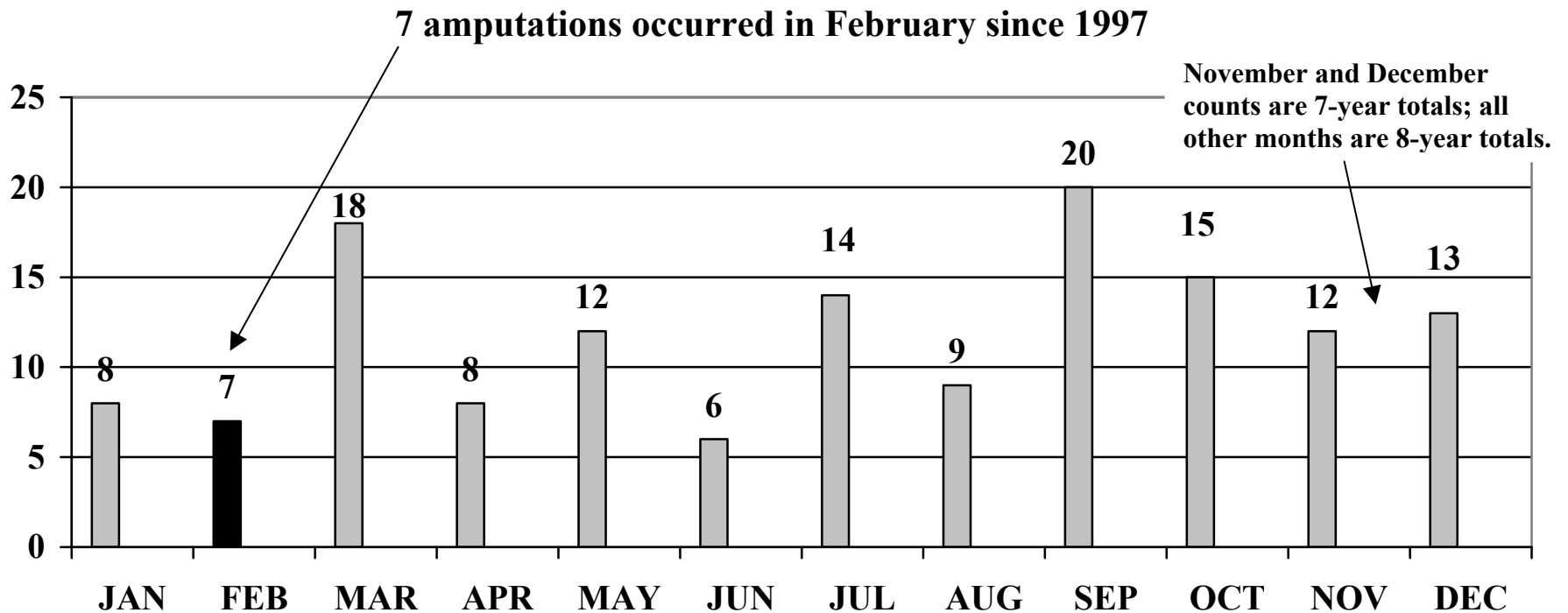
1,024 Severe Injuries occurred from January 1997 through October 2004
132.4 Severe Injuries occur on average each year**

** Latest month available from Federal Railroad Administration files.

7 Amputations (a type of Severe Injury) in February (January 1997 to October 2004)

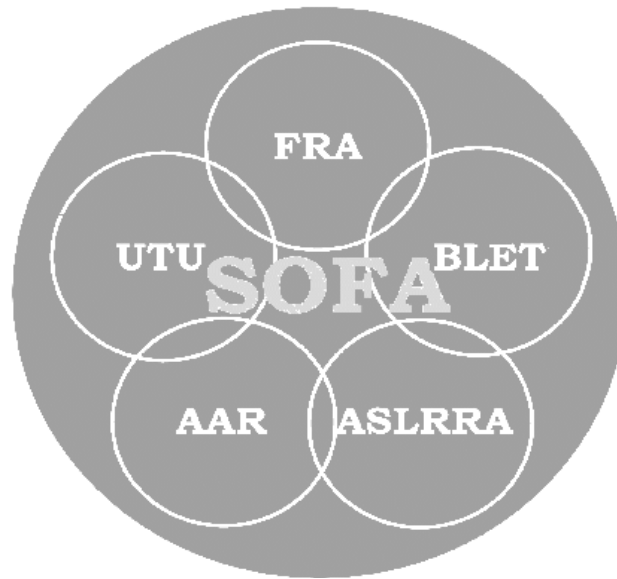
Amputations are a type of SOFA-defined Severe Injury and are counted in Severe Injuries.

Amputations are displayed separately because of the extreme nature of trauma to employees engaged in switching operations, and the potential for permanent occupational limitation.



142 amputations occurred from January 1997 through October 2004*
18.4 amputations occur on average each year

* Latest month available from Federal Railroad Administration files.

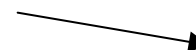


Switching Fatalities

8 February Switching Fatalities, 1992 through 2004

How quickly
switching fatalities
can occur.

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 | Movement Direction | SOFA Recommendation | Special Switching Hazard |
|---|---------|------|------------------|-----|---------------|----------------|----------------------|-------------------------|---------------------------------------|-------------------------|---------------------|--------------------------|
| 1 | 2/17/95 | CR | St. James, OH | 48 | 29 | road conductor | walking | near on-track equipment | struck by on-track equipment | shoved | 3,4 | -- |
| 2 | 2/24/95 | ATSF | Amarillo, TX | 44 | 19 | yard conductor | installing | on track | struck by on-track equipment | free-running | 1,2 | -- |
| 3 | 2/02/97 | CR | Burns Harbor, IN | 54 | 27 | yard conductor | standing | beside track | struck by on-track equipment | shoved | 2 | -- |
| 4 | 2/04/98 | BRC | Bedford Park, IL | 42 | 23 | yard conductor | standing | between track | sudden movement of on-track equipment | free-running | 2 | -- |
| 5 | 2/17/99 | KCS | Kansas City, MO | 26 | 7 | yard conductor | walking | beside track | struck by object | (not applicable) | -- | struck by motor vehicle |
| 6 | 2/11/03 | CNIC | Flat Rock, MI | 57 | 31 | yard brakeman | walking | on track | struck by on-track equipment | shoved | 2 | -- |
| 7 | 2/16/03 | CSXT | Syracuse, NY | 36 | 2.5 | yard brakeman | walking | on track | struck by on-track equipment | shoved and free-running | -- | free-rolling railcars |
| 8 | 2/18/03 | CSXT | Cheektowaga, NY | 51 | 29 | road conductor | releasing handbrakes | on end of car | 64 | shoved and free-running | -- | unsecured cars |

8 February Switching Fatalities, 1992 through 2004 (continued)

- **The average age of the employees was 44.8 years; average length of service was 20.9 years.**
- **Five of the employees – 63 percent – had 20 or more years of service. A sixth employee had 19 years of service.**
- **In 2003, three February fatalities occurred within 7 days of each other:**
 - **Flat Rock, MI, Feb. 11 (Tuesday)**
 - **Syracuse, NY, Feb. 16 (Sunday)**
 - **Cheektowaga, NY, Feb. 18 (Tuesday)**
- **Shoving and free-moving were the direction of movement in 6 fatalities. Shoving is a Special Switching Hazard requiring extreme caution. Fifty-three (53) percent of all switching fatalities involve shoving.**

Day of Week and Time of 8 February Switching Fatalities

| # | Date | RR | Location | Day of Week | Time |
|---|---------|------|------------------|-------------|----------|
| 1 | 2/17/95 | CR | St. James, OH | Friday | 11:15 AM |
| 2 | 2/24/95 | ATSF | Amarillo, TX | Friday | 9:45 AM |
| 3 | 2/02/97 | CR | Burns Harbor, IN | Sunday | 9:55 PM |
| 4 | 2/04/98 | BRC | Bedford Park, IL | Wednesday | 5:33 PM |
| 5 | 2/17/99 | KCS | Kansas City, MO | Wednesday | 7:05 PM |
| 6 | 2/11/03 | CNIC | Flat Rock, MI | Tuesday | 4:55 PM |
| 7 | 2/16/03 | CSXT | Syracuse, NY | Sunday | 12:24 AM |
| 8 | 2/18/03 | CSXT | Cheektowaga, NY | Tuesday | 12:45 PM |

Narratives of 8 February Switching Fatalities

SOFA Recommendation and/or Special Switching Hazard

1 February 17, 1995 – CR – St. James, OH

Recommendation 3, 4

Arbitrary change in switching operations by conductor resulted in him being unexpectedly struck and fatally injured by approaching cars while he was fouling the track.

2 February 24, 1995 – Amarillo, TX

Recommendation 1,2

Two crews working in the same yard from opposite ends, one crew dropped ten free rolling cars in on top of the cut where the other crew's foreman was installing the E.O.T. at the opposite end. Cars impacted with sufficient force to knock down and run over the foreman.

3 February 02, 1997 – CR – Burns Harbor, IN

Recommendation 2

Two yard jobs working on adjacent tracks. The conductor of one is studying his switch list as the other job is shoving into the adjacent track. Conductor is struck and killed by the lead car of the adjacent track shove move.

4 February 04, 1998 – BRC – Bedford Park, IL

Recommendation 2

Conductor and switchman making hoses on track 12, last transmission by conductor is "I think I got all the hoses after that next one...." Conductor later found to have been struck and killed by a free rolling car on the adjacent track.

5 February 17, 1999 – KCS – Kansas City, MO

Struck by Motor Vehicle...

A three-person switching crew was working in a piggy-back facility and had just finished shoving a cut of cars down a track to be worked by the piggy-packers (equipment used to load and unload TOFC/COFC rail shipments). The conductor was returning to the locomotive when he was struck and killed by one of the piggy-packers.

Narratives of 8 February Switching Fatalities (continued)

SOFA Recommendation and/or Special Switching Hazards

6 February 11, 2003 – CNIC – Flat Rock, MI

Recommendation 2

A three-person crew (engineer, conductor, brakeman) was stopped and the engineer and conductor were awaiting the brakeman's return from the "Trim Shanty". During this time, another crew was in the process of shoving a cut of cars down a track that was located between where the brakeman's crew was waiting and the Shanty. The brakeman exited the Shanty and was struck by the shove move as he crossed the tracks to get to his crew. The shove move was being preceded by two of the striking train's crew who were riding in a van at the time.

7 February 16, 2003 – CSX – Syracuse, NY

Free-Rolling Railcars

A two-person crew was flat switching in a yard when the switchman, needed a break. He mentioned it to the yard foreman and they decided to go to break after one last car was "kicked" into a specific track. A short time after the car had been released, the foreman's operating control unit indicated a "no poll" failure and the locomotive shut down. When the foreman couldn't contact the switchman he went looking for him. The brakeman was found struck and killed by the last car that had been "kicked".

8 February 18, 2003 – CSX – Cheektowaga, NY

Unsecured Cars

A three-person switching crew was in the process of shoving cars into a track at an industry. The switch foreman was riding the leading end of the shove and directing the move when he was struck by the cut of cars that they had left on another track and which had rolled out and into his shove move.

15 Roll-By/Struck-by-Mainline-Train Fatalities

Recently, there have been three roll-by/struck-by-mainline-train fatalities:

On January 10, 2005, a UP conductor with 32 years of service was struck by a mainline train when he stepped out from between the cars of his train.

On December 17, 2004, a BNSF conductor, while stopped on a siding track to meet an opposing train, detrained to perform a roll-by inspection of a passing train. Conductor stepped off his train and was apparently struck by the opposing UP train.

On November 01, 2004, a BNSF conductor, while stopped on a siding track to meet an opposing train, detrained to perform a roll-by inspection of a passing train. Conductor stepped off his train and was apparently struck by the opposing train.

Since 1992, there have been twelve roll-by/struck-by-mainline-train fatalities in addition to these three recent ones. Employees on the ground were struck by mainline trains while performing roll-by inspections, inspecting equipment, or getting on and off their equipment.

Fifteen Roll-By/Struck-by-Mainline-Train Fatalities

| | Date | RR | Location | SOFA Operating Recommendation | Special Switching Hazard |
|----|----------|------|-------------------|-------------------------------|--------------------------|
| 1 | 07/07/92 | SSW | Conlen Siding, TX | none | struck by mainline train |
| 2 | 04/13/93 | CSX | Dwale, KY | none | struck by mainline train |
| 3 | 12/05/93 | SOU | Atlanta, GA | Recommendation 3 | |
| 4 | 07/07/96 | NS | Sidney, IN | Recommendation 5 | |
| 5 | 07/18/97 | MNCW | Stamford, CT | none | struck by mainline train |
| 6 | 12/02/97 | BNSF | Emporia, KS | none | struck by mainline train |
| 7 | 12/28/00 | UP | Dupo, IL | none | struck by mainline train |
| 8 | 12/29/00 | BNSF | Gillette, WY | none | struck by mainline train |
| 9 | 01/10/01 | CSX | Chicago, IL | Recommendation 5 | |
| 10 | 01/11/01 | NS | South Fork, PA | Recommendation 3 | |
| 11 | 12/24/01 | NS | Lynchburg, VA | none | close clearance* |
| 12 | 03/21/02 | NS | Claymont, DE | none | close clearance* |
| 13 | 11/01/04 | BNSF | Bowdoin, MT | _____ | investigation ongoing |
| 14 | 12/16/04 | BNSF | Radium, CO | _____ | investigation ongoing |
| 15 | 01/10/05 | UP | Buena Vista, AR | _____ | investigation ongoing |

* 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.

Narrative Description of 15 Roll-By/Struck-by-Mainline-Train Fatalities

These four cases involve very similar circumstances and, in each, reflect an effort on the part of the conductor to comply with certain railroad operating rule(s) that require, in general, that passing trains be visually inspected on both sides, by the crew of the standing train. This requires that one crew member of the standing train cross over the track ahead of the oncoming train and position himself properly to ensure a good visual inspection.

1 July 07, 1996 – NS – Sidney, IN

Road crew, engineer and conductor, while stopped on siding track to meet an opposing train, FE (conductor) detrained to perform a roll-by inspection of other train. FE stepped off his train shortly before opposing trains arrival then stood in that trains track while trying to adjust his portable radio. Opposing train struck FE at this point. FE had one year of experience.

2 December 29, 2000 – BNSF – Gillette, WY

A two-person freight train crew was about to be passed by another freight train at a location on line-of-road. The conductor of the stopped train got up out of his seat, exited the leading locomotive and crossed over the track on which the on-coming train was proceeding. The conductor was struck and killed by the lead locomotive of the passing train.

3 November 01, 2004 – BNSF – Bowdoin, MT

[investigation ongoing]

A BNSF conductor, while stopped on a siding track to meet an opposing train, FE (conductor) detrained to perform a roll-by inspection of a passing train. FE stepped off his train and was apparently struck by the opposing train.

4 December 17, 2004 – BNSF – Radium, CO

[investigation ongoing]

A BNSF conductor, while stopped on a siding track to meet an opposing train, FE (conductor) detrained to perform a roll-by inspection of a passing train. FE stepped off his train and was apparently struck by the opposing UP train.

Narrative Description of 15 Roll-By/Struck-by-Mainline-Train Fatalities (continued)

The 11 remaining cases listed below have various contributing causes that led to the fatality and some are remarkably similar to those cases shown above. However, in all cases, the fatality appears to have lost his or her situational awareness just for a moment and it cost them their life.

5 July 07, 1992 – SSW – Conlen Siding, TX

A two-person crew was called to deadhead to a siding and bring the train that was there and tied down into the yard. Upon arrival at the train, the conductor began releasing handbrakes on the train and the engineer began releasing handbrakes and inspecting the four head end locomotives. An approaching 60 MPH mainline train whistled for a highway crossing at grade and the conductor stopped what he was doing and positioned himself to do a roll by train inspection. His engineer was killed when he was struck by the passing train as he stepped out from between two of his units and began walking adjacent to, and in the foul of, the main track.

6 April 13, 1993 – CSX - Dwale, KY

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.

7 December 05, 1993 – SOU – Atlanta, GA

Change in operating procedure between two crews swapping equipment resulted in conductor being struck by unexpected movement while he was in the foul of the track.

8 July 18, 1997 – MNCW – Stamford, CT

A conductor/flagman was assigned to protect contractor workers that were installing construction poles near a passenger station platform. To better observe the work, the conductor/flagman placed himself within the gauge of a “live” main track and was struck and killed by a passing train.

9 December 02, 1997 – BNSF – Emporia, KS

The three-person crew had just finished making up their train at the yard. The conductor, for unknown reasons, had positioned himself on the “live” main trackside of his train, near the second and third locomotives. The conductor was struck and killed by a passing main track train that had approached the area from the opposite direction than that the conductor’s train was to proceed.

Narrative Description of 15 Roll-By/Struck-by-Mainline-Train Fatalities (continued)

10 December 28, 2000 – UP – Dupo, IL

A three-person yard switching crew was in the process of pulling cars down a long lead that ran parallel to a main track. The switchman was standing between the cars that were being pulled out onto the lead and the main track. While the cars were being moved, a main line train approached his location. The switchman, with nowhere to go, was struck by the passing main line train and killed by a blow to the head.

11 January 10, 2001 – CSX – Chicago, IL

Conductor with 14-months service was struck and killed by passing mainline train while attempting to board locomotive at crew-change point.

12 January 11, 2001 – NS – South Fork, PA

The engineer and conductor of a road train were told to stop and check their locomotives for flat spots. Once stopped, and without a job briefing the locomotive engineer left the lead unit and shortly thereafter, was struck and killed by a passing mainline train.

13 December 24, 2001 – NS – Lynchburg, VA

A conductor, engineer and conductor in training had been transported to an unattended train standing on a siding a portion of which was in a tunnel adjacent to the main track. After storing their equipment, the conductor and the conductor in training left the locomotive to release hand brakes on the train. The conductor was killed when she failed to step in between two boxcars of her train as the conductor in training had done and was subsequently struck by a passing mainline train.

14 March 21, 2002 – NS – Claymont, DE

A locomotive engineer had been dropped off at the head end of his train while the conductor was taken to the rear to check on the REM. After crossing over the ATK corridor mainline tracks, and beginning to board his locomotive, the engineer was dragged off the stairs of the locomotive and killed by a passing 110 MPH passenger train.

15 January 10, 2005 – UP – Buena Vista, AR

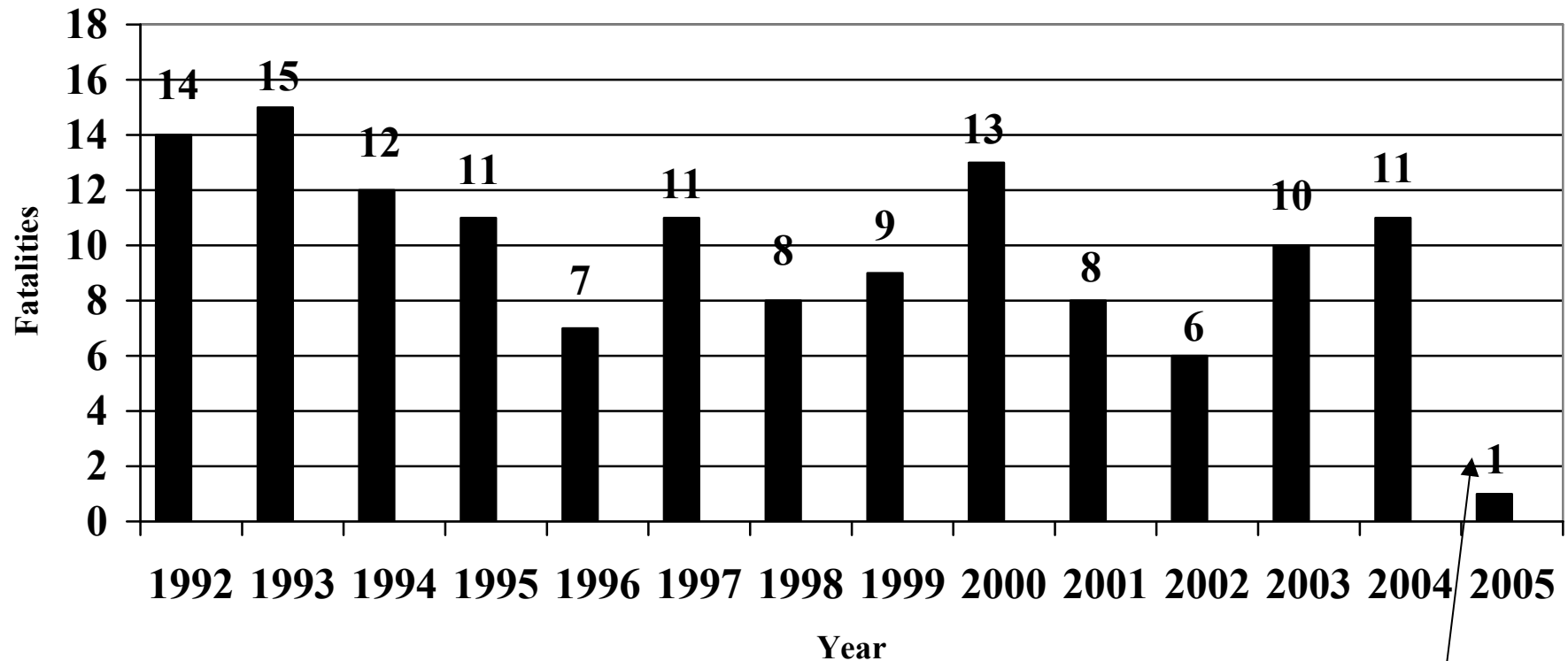
[investigation ongoing]

A conductor with 32 years of service was struck by a mainline train when he stepped out from between the cars of his train.

136 Switching Fatalities Since 1992 (through January 10, 2005)

The Switching Operations Fatality Analysis (SOFA) Group reviews each switching fatalities after the Federal Railroad Administration completes its investigation. There have been 136 fatalities since 1992. There were 11 fatalities in 2004. And 1 fatality has occurred in 2005 through January 10.

On average, 10.3 switching fatalities occur each year.



through January 10, 2005

1 Switching Fatalities in 2005 through January 10

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.

11 Switching Fatalities in 2004

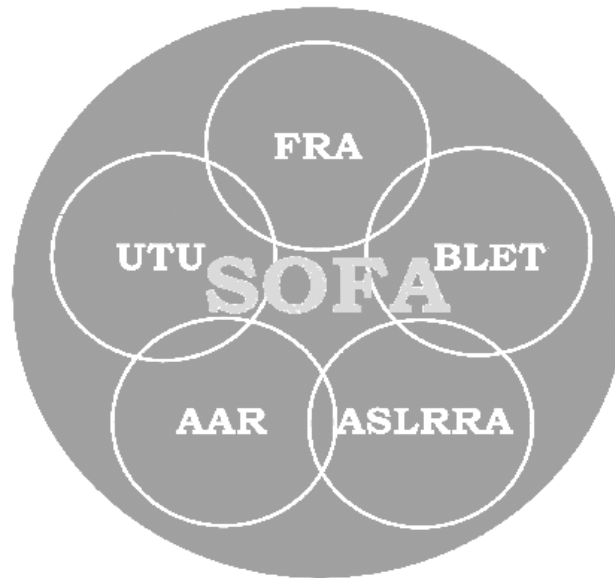
1. **JAN 14**.....Norfolk Southern (NS) conductor, with 4 years of service, killed when struck by a train he was switching in Kankakee Yard, Kankakee, IL.
2. **MAR 10**...46-year old Metro North Commuter Rail (MNCW) conductor, with 27 years of service, killed when struck by his own equipment at the Metro North Stamford Yard, Stamford, CT.
3. **MAY 13**...38-year old Michigan Southern Railroad (MSO) conductor killed when he apparently slipped and fell from a car he was riding near Sturgis, MI.
4. **MAY 18**...35-year old Norfolk Southern (NS) brakeman, with 6 years of service, killed when the lead car he was riding was struck by a tractor-trailer in Elwood, IN.
5. **SEP 02**....28-year old Burlington Northern Santa Fe (BNSF) switchman was killed when the tank car he was riding derailed during a shove move near Clovis, NM.

(Note: Information on the eleven switching fatalities is preliminary, pending investigation.)

11 Switching Fatalities Occurred in 2004 (continued)

6. **SEP 20**....44-year old Ann Arbor Railroad (AA) brakeman killed when crushed between track equipment and the car he was handling in Saline, MI.
7. **OCT 04**...58-year old Norfolk Southern (NS) conductor was struck and killed by a shove move being performed by another crew when he stepped in front of the leading end of the move in Harrisburg, PA.
8. **OCT 07**...Union Pacific (UP) student trainman killed while walking along side a shove move in Springfield, IL. Several cars derailed, one landing on the trainman.
9. **OCT 07**...60-year old Burlington Northern Santa Fe (BNSF) trainman killed when cars he was between moved in Teague, TX.
10. **NOV 01**...47-year-old Burlington Northern Santa Fe (BNSF) conductor killed when struck by a passing train, he was positioning himself to observe, in Bowdoin, MT.
11. **DEC 17**....Burlington Northern Santa Fe (BNSF) conductor, with 25 years of service, was struck by a passing train he was trying to observe at Radium, Colorado.

(Note: Information on the eleven switching fatalities is preliminary, pending investigation.)



SOFA-defined Severe Injuries

SOFA-defined Severe Injuries ¹

Injuries

Amputations ²

January 1992 to October 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 | 5 | 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 |
| YTD ³ | 109 | 119 | 116 | 106 | 115 | 100 | 96 | 97 | 14 | 24 | 16 | 13 | 15 | 10 | 12 | 13 |
| NOV | 12 | 9 | 12 | 11 | 13 | 14 | 10 | | 2 | 2 | 2 | 2 | 3 | 0 | 1 | |
| DEC | 18 | 9 | 7 | 22 | 12 | 9 | 8 | | 4 | 1 | 0 | 4 | 1 | 1 | 2 | |
| totals | 139 | 137 | 135 | 139 | 140 | 123 | 114 | | 20 | 27 | 18 | 19 | 19 | 11 | 15 | |

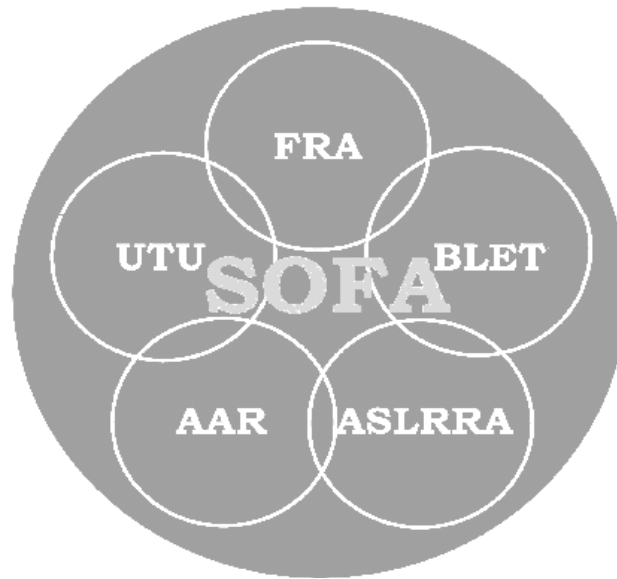
The previous seven years have averaged 108.7 Severe Injuries for the period January through October.

The previous seven years have averaged 14.9 amputations for the period January through October.

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 October is the latest month of Severe Injuries available from the FRA's Web site as of January 6, 2005.



Prevention

February Switching Fatalities

Four of the 8 February switching fatalities involved SOFA Recommendation 2*:

SOFA Operating Recommendation 2

When two or more train crews are simultaneously performing work in the same yard or industry tracks, extra precautions must be taken:

SAME TRACK

- Two or more crews are prohibited from switching into the same track at the same time, without establishing direct communication with all crew members involved.

ADJACENT TRACK

- Protection must be afforded when there is the possibility of movement on adjacent track(s). Each crew will arrange positive protection for (an) adjacent track(s) through positive communication with yardmaster and/or other crew members.

One February switching fatalities involved SOFA Recommendations 3 and 4.

Three of 8 February switching fatalities involved Special Switching Hazards:

- struck by motor vehicle
- free-rolling railcars
- unsecured cars

*** One of these fatalities involved Recommendation 1 as well.**

Preventing Roll-By/Struck-by-Mainline-Train Fatalities

Since 1992, nine of the 15 roll-by/struck-by-mainline-train fatalities (60 percent) occurred in the last five years. This clustering in time potentially represents a trend, indicating that future such fatalities may occur.

The SOFA Working Group (SWG) believes 2 of the 15 roll-by/struck-by-mainline-train fatalities were preventable by SOFA Recommendations 3; and 2 other fatalities, by SOFA Recommendation 5. (These Recommendations are cited below.)

For the other 11 roll-by/struck-by-mainline-train fatalities, at this time the SWG can only offer advice from its recent report, *Findings and Recommendations of the SOFA Working Group: August 2004 Update*:

“...[roll-by/struck-by-mainline-train] fatalities not involving an Operating Recommendation did not occur for a single reason or for a few reasons. Other than general vigilance, awareness, and alertness to the switching environment, it is difficult to prescribe a preventive measure.” p. 51

Preventing Roll-By/Struck-by-Mainline-Train Fatalities (continued)

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.

Recommendation 5

Crew members with less than one year of service must have special attention paid to safety awareness, service qualifications, on-the-job training, physical plant familiarity, and overall ability to perform service safely and efficiently. Programs such as peer review, mentoring, and supervisory observation must be utilized to insure employees are able to perform service in a safe manner.

Lifesaver 5

Mentor less experienced employees to perform service safely.

Discussion 5

While classroom-training time has increased, in general, the SOFA group has focused on experience and on-the-job training. We have found that limited training and experience continues to factor into many switching operation fatalities. Additional on-the-job training and experience, while working with more experienced peers, may help reduce fatalities among crew members with limited service.

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.

The Five Lifesavers (based on the Five SOFA Recommendations)

The SWG urges employees engaged in switching operations to practice at all times The Five Lifesavers. The 'Lifesavers' are a condensed version of the Five Operating Recommendations contained in *Findings and Recommendations of the SOFA Working Group* (October 1999), available electronically at the Federal Railroad Administration's Web site, on the Switching Operations Fatality Analysis page, at: <http://www.fra.dot.gov/us/content/102>

- **Secure equipment before action is taken.**
- **Protect employees against moving equipment.**
- **Discuss safety at the beginning of a job or when a project changes.**
- **Communicate before action is taken.**
- **Mentor less experienced employees to perform service safely.**

Obtaining Electronic Versions of SOFA Reports

The SOFA Working Group has issued four reports on fatalities and SOFA-defined Severe Injuries to employees engaged in switching operations. These reports are electronically available at the Federal Railroad Administration's Web site, on the Switching Operations Fatality Analysis page, at: <http://www.fra.dot.gov/us/content/102>

October 1999: *Findings and Recommendations of the SOFA Working Group.*

August 2000: *Findings and Recommendations of the SOFA Working Group, Appendix – Volume II.*

July 2001: *Severe Injuries to Train and Engine Service Employees: Data Description and Injury Characteristics.*

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