Brotherhood of Locomotive Engineers and Trainmen

A Division of the Rail Conference
International Brotherhood of
Teamsters

Safety Task Force

INDEPENDENCE, OHIO

Before the National Transportation Safety Board

NTSB Accident Number: DCA-17-FR-009

Class: Regional

June 10, 2017

Proposed findings, probable cause, and safety recommendations, in connection with Long Island Rail Road ("LIRR") commuter Train No. 7623 fatally striking a LIRR Maintenance of Way Track Foreman in Queens, New York on June 10, 2017.

Stephen J. Bruno, BLET-Safety Task Force, National Chairman
Donald Hill, BLET-Safety Task Force, Party Spokesman

FINAL SUBMISSSION

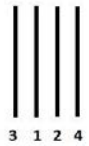
ACCIDENT SYNOPSIS

On Wednesday, June 10, 2017, at 10:13 a.m. Eastern Daylight Time ("EDT)[1] a westbound Long Island Rail Road ("LIRR") commuter Train No. 7623 traveling on Main Track No. 3 fatally struck the Foreman of a Maintenance of Way ("MOW") work group. The accident occurred inside of Queens Interlocking at milepost ("MP") 13.3 which is located west of Queens Village Station. The weather at the time of the accident was partly cloudy, temperature 80° Fahrenheit and visibility over ten (10) miles.

ACCIDENT NARRATIVE

Due to a special annual event (Belmont Stakes Horse Race) LIRR had increased the level of train service. Additionally, LIRR utilized extra MOW personnel to handle the increased service. On the day of the incident, the fatally injured Track Foreman's group, and another MOW group, were working standby for maintenance near Queens Interlocking.

In the area of the accident, there are four (4) tracks which are numbered from north to south 3-1-2-4. The direction of travel is east/west.



[1] All times throughout this report will be Eastern Daylight Time "EDT".

The affected MOW group consisted of five (5) personnel, who reported for duty at Queens Freight, (located west of Queens Interlocking), for a 7:00 a.m. start time. For purposes of this submission we may refer to this group as "MOW west". The other MOW group (not involved with the accident) consisted of twelve (12) personnel who reported for duty at Queens Headquarters (located east of Queens Interlocking Tower), for a 7:00 a.m. start time. For Purposes of this submission we may refer to this group as "MOW east".

At approximately 9:00 a.m., the fatally injured Track Foreman received instructions from the Assistant Supervisor of Track for his MOW group (MOW west) to conduct a walking inspection of the mainline tracks within Queens Interlocking and to focus their inspection on insulated rail joints, bolts, and rail clips. The Track Foreman performed a job briefing with the group and decided they would utilize "Train Approach Warning" ("TAW") as the method of on-track protection for the gang as trains approached their work location. The relevant Federal Railroad Administration regulations state the following:

> 49 C.F.R. § 214.329 Train approach warning provided by watchmen/lookouts.
>
> Roadway workers in a roadway work group who foul any track outside of working limits shall be given warning of approaching trains by one or more watchmen/lookouts in accordance with the following provisions:
>
> (a) Train approach warning shall be given in sufficient time to enable each roadway worker to move to and occupy a previously arranged place of safety not less than 15 seconds before a train moving at the maximum authorized speed on that track can pass the location of the roadway worker. The place of safety to be occupied upon the approach of a train may not be on a track, unless working limits are established on that track.

At approximately 9:15 a.m., the MOW west group began walking east toward Queens Interlocking from Queens Freight. At approximately 9:25 a.m., they began inspecting Main Tracks No. 4 and No. 2. They continued walking east through the interlocking until they met the MOW east group, near Signal Bridge No. 2, who were conducting a similar inspection.

The MOW west work group turned and proceeded to walk westward towards Queens Village Station, now inspecting Main Tracks No. 1 and No. 3. As they were conducting their inspection, they were walking within the gauge of the rail on Main Track No. 1, and an eastbound train passed on Main Track No. 4. As the rear of the eastbound passed them LIRR Train No. 7623 approached on Main Track No. 3 traveling westbound at approximately 78 miles per hour ("MPH").[2]

According to interviews, as Train No. 7623 approached the MOW west work group, the Watchman reportedly gave an audible warning using an airhorn and displayed a disc. Except for the Track Foreman, the MOW west group (who were walking within the gauge of Main Track No. 1) remained in Main Track No. 1 as train No. 7623 approached, and passed their location on Main Track No.3.

At approximately 10:13 a.m., the MOW west Track Foreman walked towards Main Track No. 3 just prior to the lead cab control car of train No. 7623 approached him, which struck him at 78 MPH at MP 13.3 .

Figure 1. ***See photo below of approximate location of where Foreman was struck (MP 13.3):***

[2] From the data download off the event recorder. The maximum authorized speed ("MAS") through Queens Interlocking is 80 MPH.

TRAIN OPERATIONS:

The Metropolitan Transportation Authority ("MTA") is the parent company of the LIRR. The incident train, LIRR Train No. 7623, is a commuter passenger train originating from the Huntington passenger station on the Port Jefferson Branch at MP 34.7 destined for Penn Station, NY at MP 0.0.

LIRR No. 7623 TRAIN CREW:

- Locomotive Engineer
- Conductor
- Assistant Conductor/Brakeman (AC)
- Assistant Conductor/Collector

Train No. 7623 consisted of twelve (12) electric multiple-unit passenger cars — Nos. 7695, 7696, 7403, 7404, 7417, 7418, 7625, 7626, 7049, 7050, 7743 and 7744 — that were powered by a third rail.[3] These cars are paired together as designated sets, the sets are then coupled together for dedicated trainsets, and were built by Bombardier, Inc. between 2002 and 2007.

See photo below of an exemplar Multiple Unit train set.

[3] Third rail is an additional rail supplying electric current to power the trainset.

Method of Operation:

Operation of Train No. 7623 was governed by Automatic Block System ("ABS") Signal Rule 261.[4] Rule 261 states as follows:

> On portions of the railroad and on tracks specified in the timetable, trains will be governed by block signals whose indications will supersede the superiority of trains for both opposing and following movements on the same track. Trains MUST NOT clear or enter the main track at a switch not equipped with an electric lock without Form L authority.

Operations Manuals:

- LIRR Rules of the Operating Department, third edition, effective May 22, 2017.
- LIRR Transportation Department Safety Rules, effective September 4, 2012.

General Orders/Notices in effect:

- General Order No. 301 – Long Island Rail Road Timetable and Special Instruction No. 3 effective May 22, 2017.

LIRR Train No. 7623 Locomotive Engineer Interview:

The Locomotive Engineer began employment with LIRR in November 2014 and his days off were Thursday, June 8 and Friday, June 9. On Saturday, June 10 and Sunday, June 11 his scheduled on-duty time was 2:19 a.m., and scheduled off-duty time was 10:35 a.m.

The Locomotive Engineer stated he first saw the MOW west work group on or about the tracks in Queens Interlocking as Train No. 7623 passed Floral Park (MP 14.9, over 1½ miles from the incident). As Train No. 7623 got closer, he sounded the horn, blowing the Operating Rule 14L sequence (two longs, a short, and a long — — o —), which he stated is required when there are MOW personnel near the tracks. He stated the Watchman, on the east end of the work group, acknowledged him by holding up the whistle post (disc) and he acknowledged the Watchman back by giving two blows on his horn.

[4] Automatic Block Signal System (ABS) is a block signal system wherein each block is governed by automatic signal, cab signal or both.

The Locomotive Engineer stated that the MOW groupwere bunched together in front of Queens Tower and that one (1) MOW employee was west of the group. As Train No. 7623 approached, most of the MOW group backed off and acknowledged the train. One (1) MOW person (the fatally injured Track Foreman) did not acknowledge the train and continued walking westward.

The Locomotive Engineer stated that he sounded the horn again as the train passed the MOW west group. As the train drew closer to the Track Foreman, the Track Foreman drifted towards Main Track No. 3 as he heard the train strike the Track Foreman. The Locomotive Engineer stated it appeared that the Track Foreman bent over to pick up something prior to the sound of striking something, as the Locomotive Engineer placed the train into emergency (the Locomotive Engineer did not observe the train striking the Foreman).

MOW Personnel Interviews:

Investigators interviewed the four (4) MOW employees who worked with the Track Foreman all recalled seeing the train; one (1) member recalled the train being very close to their location when they became aware of it. The MOW west work group had various accounts of the number of trains that passed their location prior to the accident.

All workers interviewed said that they "typically" clear the tracks completely to the field side of the right of way. They further stated that at times they felt it was safer for them to remain in a live track as a train passed on the adjacent track.

Watchman:

The Watchman worked as a Track Worker and normally acts as the Watchman when the Train Approach Warning ("TAW") method of on-track safety is utilized. He recalled reporting to Queens Freight at about 7:00 a.m., and that the Track Foreman received a call at about 8:30 a.m., instructing the Track Foreman to have the work group walk Queens Interlocking. The Watchman stated that the MOW west work group started walking east, met up with another MOW east work group, and then turned and began walking west. He did not recall the numbers of trains that passed prior to the accident.

The Watchman further stated that he saw the accident train approaching when it was at Bellerose Station. He said that he blew the Watchman air horn twice and "told my guys, I got a westbound on the outside." He said that they remained on Track No.1 because they knew Train No. 7623 was coming on Track No. 3 (the outside track). The Watchman recalled that he was positioned furthest away from the Track Foreman and could not recall how or if the Track Foreman acknowledged the warning he gave for the approaching train.

When asked about the details of the Queens Interlocking, the Watchman stated that he thought the train speed was "like 70 miles per hour".

Boom Truck/Track Worker

The Boom Truck/Track Worker began employment with the LIRR in 2004 and has worked as a Track Worker and Machine Operator, and was assigned to the Boom Truck at the time of the accident. He stated that his MOW west work group walked on Track No. 1 towards Queens Village Station. As the group was walking, he recalled two (2) trains passing.

He stated that a westbound train (Train No. 7623) approached on Track No. 3, the Watchman blew his horn and the group acknowledged. He stated that the Track Foreman was ahead of the group and that he leaned into Track No. 3. He also indicated that sometimes it would be safer to stay in the track you're on because trains may come in opposite directions at the same time.

Additionally, he stated, "the Watchman was actually 5 feet behind him, very close to me. Gave the instruction that we had one outside, okay, and we were safe right where we were. So, this is where we stayed. He held a disc up. I know that. Everybody acknowledged. [The next MOW group member in line] was right in front of me, and he was checking clips, so he knew also. We all did. We acknowledged, and [the Foreman] seemed to wave. The train blew his whistle, acknowledged where we were, and he acknowledged the disc the Watchman had. And then Mike sort of — I don't know how to explain it, but I don't know how he leaned or whatever he did, was right onto 3."

The Boom Truck/Track Worker further stated, "You can see quite a distance, so the warning was well ahead. We could have cleared safely or — *you have a clear time of 15 seconds, I think it is*.

We were well aware, at least, a half a minute to a minute ahead of time … we knew it was coming."

Welder/Truck Driver:

The Welder/Driver began employment with the LIRR in 2008 and has worked in the capacity of a Trackman. On the day of the accident he recalled the job briefing conducted by the Track Foreman at approximately 9:30 a.m., and that the method of protection was TAW.

At the time of the accident, the Welder/Driver believed that the Track Foreman was approximately 25 feet in front of him. He recalled that an eastbound train had passed their location about two or three minutes before the accident. He stated the Watchman said "westbound, outside" as Train No. 7623 approached the location.

When questioned by the investigators, the Welder/Driver stated that Train No. 7623 did not provide any warning prior to entering Queens Interlocking. *Investigators asked him about staying in a live track as a train approached or passed the inspection area. He stated that it's probably safer or one needed to clear on the north side of the tracks.*

Boom Truck Utility Driver:

The Boom Truck Driver began employment with the LIRR in 2006 and works as a machine operator. He stated that the job briefing was held approximately 9:00 a.m. or 9:15 a.m. The Boom Truck Driver further stated that he was clear of all tracks at the time of the accident. He stated if the Watchman provides warning to the group, *that the proper protocol is for the group to clear all tracks.*

The Boom Truck Driver also stated that there were several trains that passed their location, approximately nine (9) trains. He stated that the work group remained in another track for one or two of the other trains that passed them. He heard the Watchman yell out and honk his air horn, and heard the Locomotive Engineer blow the train horn. He further stated this was about 10-15 seconds prior to the incident.

Interviews of Supervisor/Foreman:

The investigators interviewed LIRR Subdivision 2 Supervisor of Track, Assistant Supervisor of Tack, Track Foreman, Switch Inspection Foreman and Engineer of Track.

The interview of the Track Supervisor and the Assistant Track Supervisor was conducted on June 13 2017, after the LIRR had a safety stand-down to heighten awareness of aspects of TAW regarding on-track safety.[6]

Track Supervisor:

The Track Supervisor stated that he is responsible of the maintenance of 106 miles of tracks and 200 switches. He stated that the type of "on-track protection" is determined by the men in the field and if track(s) were to be taken "out-of-service" he would be responsible to organize that. He stated that it's difficult for the men in the field to obtain track outage (foul-time or out-of-service).

Assistant Supervisor of Track:

The Assistant Supervisor of Track began employment with the LIRR in 2004 and worked as a Track Worker, a Track Foreman and as an Assistant Supervisor for approximately 6 years. At approximately 9:00 a.m., he received a text from the Supervisor of Track with instruction to inspect the Queens Interlocking. He relayed the message to the Track Foreman at Queens Freight and he also informed the Queens Freight MOW west work group to walk Tracks No. 2 and No. 4 down to Belmont.

When questioned by investigators, the Assistant Supervisor of Track indicated that it's normal for a MOW work group to remain on an interior track if a train is approaching them that's operating on an outside track. The Assistant Supervisor of Track was questioned after the LIRR issued a safety stand-down on the safety aspects of TAW. *He replied when questioned by the investigators that he was not aware of any changes in approved practices.*

[6] See Appendix 2 for a copy of the LIRR Red Alert Safety Bulletin

Track Foreman MOW East:

The Track Foreman began employment with the LIRR in 2004 and has been working as a Track Foreman since 2008. The Track Foreman stated that his work groups typically use TAW for routine inspection and minor correction inside the Queens Interlocking. When asked about the difficulty in getting foul time in Queens Interlocking, he stated that it's not easy.

Investigators asked when using TAW, if the Track Foreman identifies a predetermined place of safety. He replied that the determination is made as the gang proceeds with its work. When the investigators asked if he would remain in a track while a train approached his work location, he replied, "Not generally speaking, we don't, but I have."

The Track Foreman also was asked if after the accident, *has anything changed regarding clearing tracks when using TAW. He replied,* "I have discussed it with some of the other men and we have to make a determination, do I want my men walking over three live third rails where the potential is for them to trip every time I walk in and out carrying, let's say, a whacker, or their forks, or their lining bars, or whatever tools that we can't lay down on the track? Or do I have 3 miles of sight in each direction, or 2 miles of sight in each direction and I can determine that it's going to be safer just to keep my men right where I am and, if I see a train coming on another track, at that point I'll have more than enough time and I'll be able to make the determination to get everybody into a clear where, you know, where I have two trains coming and I just can't be where I am."

Switch Inspection Foreman:

The Switch Inspection Foreman began employment with the LIRR in 1996 and has worked as a Foreman for the past twelve years, and in his current position for about five years. He has worked with signal department personnel, inspecting switches. This type of work requires the use of foul-time and TAW as the workers are taking control of the switches and signals in the interlockings.

Investigators asked about whether the Switch Inspection Foreman clears live tracks when a train is approaching. He stated "We generally do. It's not always. If the train — if we're on, you know, the track on, say, like Main Line 3, which is on the north side, and the trains come on

Main Line 4, which is three tracks over on the south side, we may — I may continue looking at it, you know, with my TAW."

Additionally, the Switch Inspection Foreman was asked "If they're just using train approach warning, no foul time involved, say, they're working on one of the inside tracks and a train passes on the outside track, is that something that it would be okay for them to stay in that inside track?" He responded, "I say I believe it is as long as you can — the train that's passing is not obstructing your view to the track that you're in or, you know, the tracks between you and your predetermined place of safety."

The Switch Inspection Foreman was questioned about the LIRR Safety Alert following the accident, and whether, following the June 10, 2017 accident, he remembered any discussion or focus on this point from Long Island Rail Road?" He answered, "Specifically no."

Engineer of Track:

He stated that he hired in June 2004 and has worked the following positions: Junior-Engineer, Staff-Engineer, Assistant Engineer (Track Department), and he currently is the Supervisor for Sub-Division 2.

The Engineer of Track gave the order to the Assistant Supervisor to have the MOW west group perform the walking inspection of Queens Interlocking. When questioned by investigators about the MOW west group remaining in a live track, the Engineer of Track stated, "by rights, though, they should not stay in the track if there's a train coming. The safest route for them to do is to clear and clear all the way. Or, in fact, take foul time if they're going to be on the track …."

The following is a breakdown of the Foreman's work history:

Deceased Track Foreman's work schedule:

- Monday, June 5, 2017 — 7:30 a.m. to 5:30 p.m. (2 hours overtime)
- Tuesday, June 6, 2017 — 7:30 a.m. to 5:30 p.m. (2 hours overtime)
- Wednesday, June 7, 2017 — 7:30 a.m. to 4:00 p.m. (30 minutes overtime)
- Thursday, June 8, 2017 — 7:30 a.m. to 3:30 p.m.
  - Thursday night 10:00 p.m. to Friday 7:30 a.m. (9.5 hours overtime)
- Friday, June 9, 2017 — 7:30 a.m. to 3:30 p.m.

- Friday night 11:00 p.m. was scheduled to work until Saturday night 11:00 p.m. (24 hours overtime)

Although the deceased Track Foreman worked a significant number of hours in the days immediately prior to the accident, there is no conclusive information that fatigue was a causal or a contributing factor.

Video from platform:

A review of video secured from the LIRR I Station platform reflected the MOW west work group Watchman raising his watchman disc approximately three (3) seconds prior to Train No. 7623 striking the Track Foreman. The following is the timestamp analysis of the video (camera times not synched to train recorder times):

- **10:13:03**
  - 1) Westbound incident train lights are first visible in camera's field of view (looking east)
  - 2) The Watchman moves his disc from high to low position
- **10:13:06**
  - Foreman is struck by the westbound incident train on Main Track No. 3

PRIMARY CAUSE AND CONTRIBUTING FACTORS

The Brotherhood of Locomotive Engineers and Trainmen ("BLET") concludes that it remains undetermined why the Track Foreman of the MOW west work group leaned into the LIRR Train No. 7623 on Main Track No. 3. We believe there is insufficient information to determine whether fatigue on the part of the decedent was a contributory factor. Contributing to the cause of this accident was the practice of MOW employees using live main tracks as a place of safety when using train approach warning. Also contributing is that insufficient warning time was provided by the Watchman to the subject MOW employees. Additionally, was a failure to establish and communicate to all MOW workers the location of the pre-determined escape area.

PROPOSED FINDINGS

HUMAN PERFORMANCE:

The MOW employees' practice of using live main tracks as a haven while performing their duties led directly to this incident. It also is a fact that immediately following the accident, LIRR issued an emergency stand-down to emphasize the requirement that MOW employees clear all tracks while using TAW as their method of protection. Despite the stand-down issued by LIRR, subsequent separate sets of interviews following the stand-down revealed that MOW employees were still using live main-tracks as an escape area in certain situations.

Additionally, the Watchman's warning provided to the subject MOW employees was insufficient, as supported by video evidence and the testimony of one of the MOW employees. Also contributing was the failure to predetermine escape areas at the worksite and communicate their locations to all employees, which facilitated their decisions to continue to occupy live tracks as trains passed.

OPERATIONS:

The MOW's widely used and condoned practice of using live tracks to avoid trains on other tracks is a contributing factor.

PROPOSED RECOMMENDATIONS

To Metropolitan Transit Authority ("MTA") and Long Island Rail Road ("LIRR"):

1. Ensure that all MOW employees are aware of the requirement to clear all live tracks when utilizing TAW as their method of on-track protection.

2. Ensure that Watchmen are performing their duties without any potential interferences, able to provide adequate advance-warning, fully knowledgeable of the territory (i.e., MAS at locations where they provide protection, as necessary sight-distance calculations are required to provide the 15-second warning required by 49 C.F.R. § 214.329(a)).

3. Develop a map/chart at various locations, which provide pertinent information for the MOW employees regarding MAS in the territory where work is to be performed, and to identify predetermined escape routes as the MOW workers traverse the territory.

4. Ensure all MOW employees are advised in advance of enhanced required service so they may anticipate the impact it may have on their work/rest cycles.

5. Develop plans to coordinate work performed by MOW Trackmen with Signal employees who perform regulatory required inspections under fouling-time conditions.

To the Federal Railroad Administration ("FRA"):

1. Reinforce and audit that MOW employees clear live-main tracks as trains pass their work location.

CERTIFICATE OF MAILING

I certify that I have on this date electronically served upon Mr. Tomas Torres tomas.torres@ntsb.gov, Investigator in Charge, a full and complete copy of the "Proposed findings, probable cause, and safety recommendations" with regard to the accident of LIRR Train No. 7623 striking a MOW employee, submitted by the Brotherhood of Locomotive Engineers and Trainmen's Safety Task Force to the National Transportation Safety Board. A hard copy was also forwarded addressed to the party of interest as required by 49 CFR §845.27 (Proposed Findings).

National Transportation Safety Board
c/o Mr. Tomas Torres
Investigator in Charge, DCA17MR010
490 L' Enfant Plaza, SW
Washington, D.C. 20594
[redacted]

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Yours truly,

[redacted]

Stephen J. Bruno
Brotherhood of Locomotive Engineers & Trainmen
National Secretary Treasurer
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APPENDIX 1

1038-B (Continued)

	Miles Per Hour									
	Single Track		No. 4 Track		No. 2 Track		No. 1 Track		No.3 Track	
	Psgr	Frt	Psgr	Frt	Psgr	Frt	Psgr	Frt	Psgr	Frt
LONG BEACH BRANCH										
Valley Interlocking										
Curve at Valley Interlocking Station	....	....	....	....	45	45	....	.....	....	....
Between:										
Valley and Lead East on 2; West on 1	....	....	....	....	60	40	60	40	....	....
Valley and Lead West on 2; East on 1	....	....	....	....	40	30	40	30	....	....
Except:										
First curve east of Lynbrook and east end of Centre Avenue station platform	....	....	....	....	45	....	45	....	....	....
Curve east end East Rockaway Station	....	....	....	....	45	....	45	....	....	....
Curve east of Oceanside	....	....	....	....	45	....	45	....	....	....
Curve, Island Park	....	....	....	....	45	....	45	....	....	....
Lead Interlocking	30	15	....	....	....	....	....	....	....	....
MAIN LINE										
Between:										
Harold and Mile Post 4	....	....	60	20	60	20	60	20	60	20
Mile Post 4 and Jay	....	....	80	45	80	45	80	45	80	45
Except:										
Kew Gardens & Westward limits of Jay Interlocking for Eastward Trains Only	....	....	....	35	....	35	....	35	....	...
Jay and Hall Interlocking limits			....	10	....	10	....	10	....	10
Signal Bridge 99 & Queens	....	....	80	45	80	45	80	45	80	45
Except:										
Reverse curves at west end of Hillside Viaduct	....	....	60	40	60	...	70	....	70	....
Queens Interlocking	....	....	80	45	80	45	80	45	80	45
Queens and Farm			....	....	80	45	80	45	....	....
Except: Between West End of Hicksville Station and easterly limits of Divide	....	....	....	....	40	40	40	40	....	....
Beth Interlocking and First Curve east of Beth	....	....	....	....	60	40	60	40	....	....
Farm 2 Interlocking	....	....	....	....	60	40	60	40	....	....
Farm and JS	80	45	....	....	....	....	....	....	....	....
JS and Brent	....	....	....	....	80	45	80	45	....	....
Brent and Ronkonkoma	80	45	....	....	....	....	....	....	....	....
Except:										
First curve east of MP 47	60	45								
Ronkonkoma and MR	45	30	....	....	....	....	....	....	....	....
Except: Between										
Westward Home signal at KO2 and 1st Westward interlocking signal	20	10								
MR and End of Block, GY	40	30	....	....	....	....	....	....	....	....
Except: Between										
Mile Post 73 and Mile Post 74	20	20								
MONTAUK BRANCH										
Between:										
Sig. Bridge 98 and Valley **(see note1)**	....	....	....	....	80	45	80	45	....	....
Except:										
Curve, Hillside Viaduct	....	....	....	....	60	40	60	40	....	....
Curve west of St. Albans	....	....	....	....	60	40	60	40	....	....
Reverse curves east of St. Albans	....	....	....	....	....	....	50	40	....	....
Reverse curves 3595 east of St. Albans	....	....	....	....	60	40				
Second curve west of Valley					60	40	60	40	....	....
First curve west of Valley					70	40	70	40	....	....
Valley and Babylon	....	....	....	....	80	45	80	45	....	....

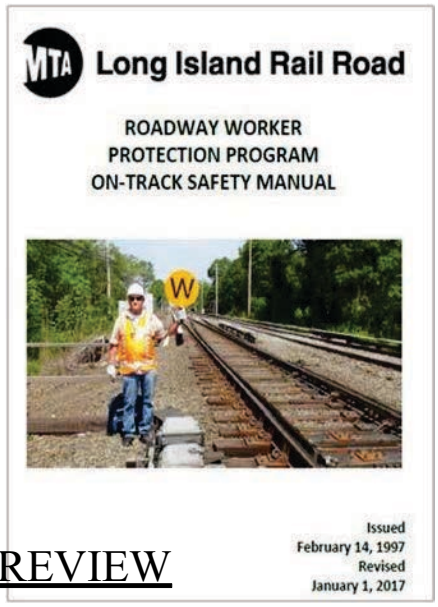
Roadway Worker Fatality Queens Village

Long Island Rail Road
Corporate Safety Department

RED ALERT

SYNOPSIS:

On Saturday, June 10, 2017 at approximately 10:12am a Track Foreman was struck by a train and fatally injured while working near Queens Village. The incident is under investigation by the NTSB and FRA.



RULES AND PROCEDURES TO REVIEW

Please review RWP rules and procedures in the RWP On Track Safety Manual including:

- Do not foul a live track without proper protection (page 16).
- Establish a Predetermined Place of Safety (PPOS) during the required job briefing (page 13).
- Everyone must be able to clear at least 15 seconds prior to the arrival of a train or other on-track equipment at their location (page 28).
- A PPOS cannot be in a track unless working limits (main track out of service, foul time, inaccessible track) are established (page 13 and 104).

RAIL RESOURCE MANAGEMENT

Situational Awareness: Remaining focused on the task at hand while following all safety and operating rules is essential at all times. All workers must have a clear understanding of the methods of protection to

be used and where to clear if applicable. Additionally, always expect train or equipment movement on any track, in either direction, at any time.

SUMMARY:

The Job Briefing is the most important safety tool when working on or near the tracks. The job briefing will include the form of roadway worker protection to be used, site specific hazards, predetermined place of safety, track speed, adjacent track protection, and other relevant information as outlined in the RWP On Track Safety Manual. If conditions change you must clear the tracks and hold an additional job briefing.

This Red Alert bulletin does not supersede the Operating Rules or Special Instructions. If you have any questions, please contact the proper authority.

DRAFT