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: RRD-19FR004

Class: REGIONAL February 7, 2019

Proposed findings, probable cause, and safety recommendations in connection with the switching fatality on Norfolk Southern Railway Company ("NS") at Bayview Yard, in Baltimore, Maryland.

Stephen J. Bruno, BLET-Safety Task Force, National Chairman
L. Randy Fannon, BLET-Safety Task Force, Party Spokesman

FINAL SUBMISSION

The Brotherhood of Locomotive Engineers and Trainmen ("BLET"), a division of the Rail Conference of the International Brotherhood of Teamsters ("IBT"), was assigned party status by the Board in the above-referenced investigation. BLET respectfully submits these proposed, findings, probable cause, and safety recommendations to the Board for consideration.

Accident Synopsis:

On February 7, 2019, at approximately 7:00 a.m. Eastern Standard Time ("EST")[1] Norfolk Southern Railway ("NS")[2] road switcher[3] H63, was tasked with yarding an inbound freight train that originated in Enola, Pennsylvania. The accident occurred in NS Bayview Yard, Baltimore Terminal, located in Baltimore, Maryland. After relieving the inbound crew, the Conductor separated the first eight (8) cars from the train to pull south onto intermodal pad Track No. 4 and was instructed to leave the rear four (4) of those cars on the intermodal pad track, place the remaining four (4) cars in the classification yard and secure them. The Bayview Yardmaster[4] had instructed the crew to pass through the Bank track to the classification yard.

The accident occurred while the engine was shoving the cars northward through the Bank track. Prior to the accident, the crew was on level grade between seven (7) and five (5) miles per hour ("MPH") decreasing speed. There was standing equipment on the adjacent Perryville track. The Conductor was raked from the northwest corner of the lead car of the movement. The train was shoved approximately 570 feet from the point the Conductor mounted the rear car to the point of the accident. At the time of the accident, the weather was clear with a temperature of 44° F, and the sun was beginning to rise.

[1] All times throughout report will be Eastern Standard Time ("EST").

[2] Formerly known as Norfolk Southern Railway Company. For the remainder of this report the railroad will be referred to as "NS".

[3] A road switcher is a local service crew that can switch local industries or perform classification of rail cars in a rail yard.

[4] Yardmaster is a supervisor that controls movements into and out of a rail yard and instructs train crews on the work to be performed.

Accident Narrative:

Train Information:

NS road switcher (H63) consisted of two (2) locomotives (NS 9207 lead), and eight (8) loaded cars: four (4) general freight cars followed by four (4) loaded intermodal[5] cars. Crew members included a Locomotive Engineer and a Conductor.

Method of Operation:

The Bayview Yard is located within Baltimore Terminal, Baltimore, Maryland and is a part of the Harrisburg Division on the NS transportation network. The Terminal is the end of the line, on an island, that NS must operate its trains from Enola, Pennsylvania over the Amtrak[6] Northeast Corridor between Perryville, Maryland and Baltimore, Maryland. Trains enter the Bayview Yard upon signal indication and verbal permission of the Bayview Yardmaster.

NS Rules and/or Documents:

The below listed rules and/or documents are those that were produced by Norfolk Southern:

- *NS Safety and General Conduct Rules, effective January 1, 2019*
- *NS Operating Rules, effective January 1, 2019*
- *NS Rules for Equipment Operation and Handling, NS-1, effective January 1, 2019*
- *Harrisburg Division, Northern Region Timetable Number 1, effective September 9, 2015*

Movements of NS road switcher H63:

The train crew of NS H63 went on duty on February 7, 2019 at 6:00 a.m. in Bayview Yard, Baltimore, Maryland. Prior to the start of duty, the Locomotive Engineer was off duty for 12 hours and 5 minutes, the Conductor was off duty for 54 hours and 34 minutes. The amount of time either crew member was awake prior to the time they reported for duty remains unestablished.

[5] Intermodal railcars are designed to transport either trailers or containers on flat cars or in well cars.

[6] National Railroad Passenger Corporation or ("Amtrak").

The Conductor contacted the NS first shift Yardmaster, who instructed the crew to relieve inbound train 38A at the south end of track No. 30 and separate the head eight (8) cars, and place the rear four (4) cars onto intermodal pad Track No. 3 This left H63 with two (2) locomotives and four (4) general freight cars. The crew requested instructions from the dayshift Yardmaster for permission to proceed north through a clear intermodal track back to the classification yard. The Yardmaster would not authorize movement back through the intermodal tracks due to NS rules restricting riding equipment on intermodal pad tracks, but instructed them to shove back through the Bank Track to Track No. 30 in the classification yard and wait for further instructions.

After securing the four (4) cars on the intermodal track the conductor, walked ahead of the train to align the switches for their route. He operated two (2) switches to line up their movement, and instructed the Locomotive Engineer to pull ahead. After the Locomotive Engineer pulled by the switch, the Conductor stopped the move and lined the intermodal lead switch for normal position, and he also checked the switches for the Bank track. The Conductor then crossed over to the west side of the equipment and mounted the northwest corner of the lead car to protect the shove movement. The Conductor gave directions to the Locomotive Engineer via radio that the switches were lined for the Bank track, whereupon the Locomotive Engineer requested the Conductor to "double-check"[7] the switches. The Conductor responded that the switches were double-checked, and the route was clear for twenty (20) car lengths (approximately 1,000 feet).[8]

The Locomotive Engineer began shoving the cut of cars and reached a maximum speed of 7 MPH, eventually maintaining a speed of 5 MPH. While shoving north the Locomotive Engineer recalled a radio transmission regarding additional car lengths seen clear by the Conductor. There were no more conversations between the Locomotive Engineer and the Conductor.

As the Locomotive Engineer continued the shove north, he observed a lantern on the ground between the Bank and Perryville tracks, then observed a hat, and finally saw the Conductor lying on the ground. He immediately stopped the movement and attempted to contact the Conductor. He then contacted the Yardmaster and requested that Emergency Medical Services ("EMS") be called.

[7] "Double Check" is a NS rule 185 requiring the Locomotive Engineer to request the Conductor to take a second look at the route to make sure the switches are lined and/or all derails are off. Attachment C

[8] NS does not require crews to double check awareness of close clearances.

EMS services arrived within three (3) minutes and transported the Conductor to the emergency room.

Conductor H63 Job:

The Conductor was hired by Norfolk Southern on August 6, 2018, and entered the Conductor Training program in McDonough, Georgia. On November 2, 2018, he was promoted to Conductor on the fast track program.[9] He was then assigned to the Baltimore Terminal Conductor's extra board, where he worked on call until the February 7, 2019 incident. At the time of the accident, the Conductor was certified in accordance with the requirements of 49 CFR part 242.

Locomotive Engineer H63 Job:

The Locomotive Engineer was hired as a Conductor trainee on September 25, 2003, and subsequently promoted to Conductor on February 5, 2004, four (4) months after being hired. The Locomotive Engineer entered Locomotive Engineer training on September 4, 2007, and was promoted to Locomotive Engineer on March 20, 2008. At the time of this accident, the Locomotive Engineer was certified in accordance with the requirements of 49 CFR part 240. He was the regularly assigned Locomotive Engineer on the H63 road switcher.

Reenactment:

A reenactment of the incident was performed with the same equipment that was used on the day of the accident. The reenactment revealed an impassable close clearance was created when cars are on an adjacent track. With standing equipment on the Perryville track (the track to the west of the Bank track), there was a clearance of thirteen inches, at the South end of the standing equipment, between the hand hold of the equipment on the Bank track and the hand hold of the equipment on the Perryville track. The North end of the first car standing in the Perryville track had a clearance of merely nine inches. It is virtually impossible for a full-grown human to survive in that space.

[9] Fast track program is qualifying the trainee in sixty (60) days after beginning Phase II training on the division.

Hazard Identification:

The Bank track is located on the President's Street Branch, as noted in the Harrisburg Division Timetable No. 1. The NS informed operating crews of close clearance situations on the President's Street Branch via Special Instructions in their timetable.[10] The Baltimore Consolidated Terminal Instructions, 6. Terminal Instructions states,

> *"A. Close Clearance*
>
> *Account close clearance situations, employees are prohibited from riding the sides or end of equipment in the following locations:*
>
> > *2. Baltimore, MD (Presidents Street I. T.) – Close clearance exists on the Incline Track, Bank Track or Perryville above when cars are on adjacent tracks."*

Clearly, there were "cars on the adjacent track" in this incident and the Special Instruction prohibits riding the equipment in that "close clearance situation". The conductor's decision to ride the equipment through the yard on the Bank Track is the probable cause of this accident. However, it should be noted that. as drafted, the instructions could be construed to create an exception which allows employees to ride equipment at these locations when there are no cars on the adjacent tracks, i.e., the "situation" does not exist.

The general instruction clearly states the prohibition and item No. 2 identifies the location of the prohibition for riding equipment. The exception is established by adding qualifying language in the instruction for the prohibition. There is no need for the phrase "when cars are on adjacent tracks" unless it is to create an exception for occasions when that "situation" does not exist. We believe the intention was indeed to create an absolute prohibition for riding equipment on the Bank Track; however, the qualifying phrase indicates a different conclusion. As drafted, the language of the special instruction is imprecise and could lead to similar misunderstandings in the future. If we are to discharge our responsibility to identify and correct the conditions that contributed to this accident, which could lead to similar accidents in the future, this conflict must be addressed by

[10] Timetable, Baltimore Consolidated Terminal Instructions, 6. Terminal Instructions, A2 – "Baltimore, MD (President's Street I.T.) – Close clearance exists on the Incline Track, Bank Track or Perryville Above when cars are on adjacent tracks. Note: On Perryville Above, cars other than empty flat cars could strike equipment passing on Bank Track due to track profile. *See* Timetable Pages Appendix A.

eliminating the exception language. In addition, such ambiguity is exactly the type of circumstance that training and experience can help identify.

Norfolk Southern could not produce records to indicate if the Conductor had been trained on the restrictions, or how many times the Conductor had been in the tracks prior to the incident. Moreover, the fatally injured employee had only four months of experience as a conductor. There is no evidence that anyone advised him that there was standing equipment or that he was aware of the "close clearance situation". There certainly was no "double check" to assure the awareness of the fatal hazard as is the requirement for assuring the proper alignment of the switches.

There are several possible explanations for the conductor riding the equipment contrary to the special instruction;

1. He was aware of the prohibition and the close clearance situation and willfully rode the equipment into the hazard. This is the most unlikely of any explanation and, frankly, is not supported by anything in the conductor's work history.

2. He was aware of the prohibition but not the equipment on the adjacent Perryville Track, and believed the "close clearance situation" did not exist. This explanation seems unlikely. It is reasonable to conclude that if he was aware of the prohibition he would have checked to determine if the "close clearance situation" existed.

3. He was aware of the equipment on the adjacent Perryville track but not aware of the prohibition. This explanation seems unlikely as well since he would have been able to avoid the hazard of the close equipment if he was aware of it, even if he was unaware of the prohibition.

4. He was unaware of the prohibition and/or the equipment on the adjacent Perryville Track and believed he was permitted to ride the equipment through the Bank Track. This explanation seems most likely, especially since he was made aware, by the Yardmaster, of the prohibition of riding their equipment through the yard on the intermodal track, but not so advised of the close clearance prohibition on the Bank Track.

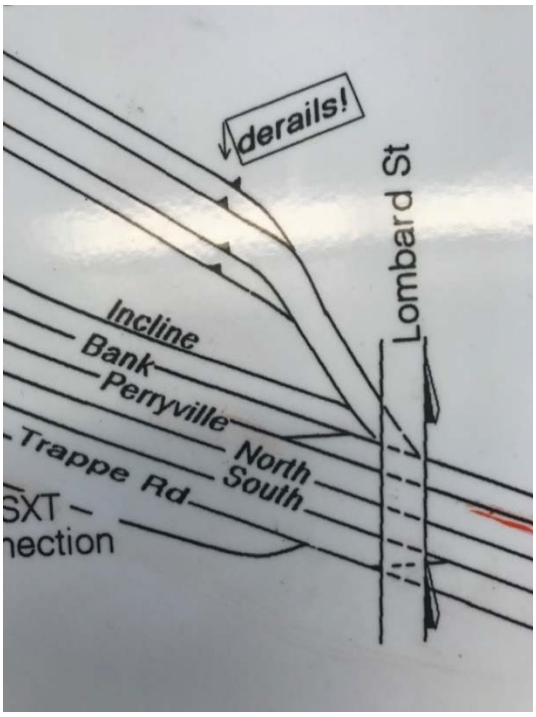

Figure 1- Intermodal tracks (from the top) tracks, 1, 2, 3, 4. The last switch operated by the Conductor is located from Track No. 3 under the Lombard Street bridge to shove north via the Bank track.

Therefore, we make two recommendations regarding this aspect of the investigation; a) clarify the special instruction by removing the qualifying phrase "when cars are on adjacent tracks", and b) implement a system-wide requirement for crews to "double check" their understanding of the existence of close clearance hazards prior to movement, similar to the requirement of NS operating rule 185.

We anticipate the railroad may be defensive of its rule as written, but the assignment of party status to the Brotherhood of Locomotive Engineers and Trainmen in this investigation is to provide subject matter expertise from the perspective of the operating employees. It is not merely the purpose of the investigation to identify the cause of the accident and certainly not to assign blame, but also to make recommendations that will help prevent similar accidents in the future. We believe that identifying and removing ambiguity from the operating rules improves safety. which is always the

goal of responsible employers. Moreover, these two recommendations, when implemented, will impose little, if any, cost to the railroad.

Training Program:

The NS training program consists of classroom training, on-the-job training, and review sessions with the Division management led by the Division Training Coordinator. The Conductor hired on August 6, 2018, as a Conductor Trainee when he reported for duty at the Norfolk Southern Training Center in McDonough, Georgia.

The training at McDonough, Georgia consisted of rules training, classroom review, and outdoor application of what is required to be a Conductor.[11] The classroom portion of the training concluded by taking exams on the rules, certification and hazardous materials training.

Upon returning to the assigned operating division, the Conductor Trainees met with the Division Training Coordinator and Division leadership. A training schedule is provided for the territories assigned, along with a mentor[12] to assist in the training process. The Conductor made 34 working trips on the Baltimore Terminal road switchers and 12 road qualifying trips between Baltimore and Harrisburg Terminal in the sixty-seven days of the on-the-job training portion of the overall training program.[13]

On November 2, 2018, the Conductor became qualified and marked up at Baltimore, Maryland's Bayview Yard. He was assigned to the Conductor's extra board protecting all yard, local, and road assignments.

As we stated above, he had only four months of experience. Moreover, Norfolk Southern could not produce records to indicate if the Conductor had been trained on the close clearance prohibitions in general. Indeed, he seemed to be unaware of that prohibition which was evinced by the crews request to ride through the yard on the intermodal track. Nor could NS establish how many

[11] Outdoor on hands training of applying/releasing hand brakes, operating switches and derails, mounting/dismounting equipment and locomotives, air brake review, and the use of a brake stick to apply and remove handbrakes.

[12] Mentor – a selected Conductor to assist in the training of Conductor trainees by providing guidance, review, and critique of their performance.

[13] *See* Conductor Promotion Packet in Docket.

times the Conductor had been in the tracks prior to the incident. We believe this was his first time in on the Bank Track. Also, the fatally injured conductor received only 67 days of Phase II training despite the railroad's previous representations to NTSB that Phase II training spanns 99 days. *See* p. 12, *infra*. The fatally injured employee received only two-thirds of the purported standard training time in Phase II of the program. Finally, the fatally injured Conductor's assigned Mentor from the training program stated that he had recommended to the Division training coordinator that the trainee needed more time in the training program. The training coordinator rejected that recommendation and qualified him without any additional training.[14]

We conclude that insufficient training combined with inexperience was a contributing factor to this accident.

Drug and Alcohol Test Results:

Federal Railroad Administration ("FRA") Post-Accident Forensic Toxicology Result Reports established negative test results for drugs and alcohol for the fatally injured Conductor and the Locomotive Engineer.

Cell Phone Records:

Cell phone records from the Conductor and Locomotive Engineer were received and, during the time of the accident, no cell phone usage was discovered.

Post-Accident Response from NS Railway:

The NS issued a Safety Alert on February 12, 2019 to the entire railway system reviewing the incident. The bulletin focused on communication, job briefings, timetable special instructions related to restricted tracks, and protecting shove moves.[15]

[14] *See* Brake interview transcript, pages 10-12 and 16-17.

[15] *See* Appendix B at the end of this report.

Probable Cause

Close Clearance Tracks and Timetable Instructions:

The cause of the accident was the conductor's decision to ride through the yard on the Bank track and pass through a close clearance when cars were on the adjacent Perryville track. The root cause (i.e., the reason the conductor attempted to do so) is less certain but must be evaluated. The most reasonable explanation for that fatal decision is that the Conductor was unaware of the prohibition and/or the equipment on the adjacent Perryville Track, and believed he was permitted to ride the equipment through the Bank Track. Contributing factors to that decision were:

1) The insufficient training he received, and

2) His inexperience as a conductor, generally, and as a conductor at that specific location.

The Norfolk Southern Harrisburg Division Timetable instructions for Baltimore and the specific tracks involved in the incident area, are not clear instructions. The prohibition in the timetable begins with the phrase, ***"Account close clearance situations, employees are prohibited from riding the sides or ends of equipment"***[16] and concludes with the phrase "when cars are on adjacent tracks". There is no reasonable way to interpret that language other than as identifying an exception to the prohibition.

Insufficient Training

The NS Conductor training program consists of six (6) months of training, unless the new hire is placed in the accelerated or "fast track" program. The time consists of the Phase I training in McDonough, Georgia, which is comprised of basic railroad training, classroom training and Conductor-specific work that is required via the NS computer system.

After completing Phase I of their training, Conductors return to the operating division that hired them for the on-the-job training, which is labeled as Phase II training. The decedent Conductor entered Phase 1 on August 6, 2018 and entered Phase 2 on August 27, 2018. He was promoted a

[16] *See* Appendix A – timetable page 230 Section 6(A).

mere sixty-seven (67) days later on November 2, 2018.[17] This is particularly concerning since this is not the first accident where insufficient training has been suspected as contributing to an employee fatality. In an investigation of a fatal accident on August 12, 2015 in Petal MS, *"The NS training coordinator told NTSB investigators that phase II of NS conductor training typically consists of 99 days of on-the-job learning, with a goal to qualify conductor trainees during this time.* (Emphasis added)

Despite the Railroad's previous representations to NTSB regarding the amount of time a trainee spends in Phase II of their training and the Conductor's Mentor stating that he recommended more training,[18] the NS qualified the Conductor based on the Training Coordinator's advice. The Division Assistant Superintendent signed off on his promotion on November 2, 2018 effectively reducing this phase of his training by approximately one-third.[19]

Norfolk Southern has not modified its training program for Conductor trainees following the Petal, MS incident. We conclude that insufficient training was a contributing factor in this accident.

[17] See Training Records in the Docket.

[18] *See* Schwarz interview transcript, pages 10-12 and 16-17.

[19] *See* NTSB report RAB 1602 (DCA15FR013 – Petal, MS).

Proposed Recommendations

To Norfolk Southern Railway:

1. Enhance the training program to document that Conductor Trainees are trained on every aspect of their assignment and are aware of restricted safety tracks that could cause injury prior to qualifying.

2. Revise the rules governing close clearance-prohibited tracks to clearly state that employees cannot ride equipment on those restricted tracks. And remove the qualifying phrase "when cars are on adjacent tracks" from the existing special instruction for Baltimore Consolidated Terminal Instructions where appropriate.

3. Implement a rule requiring a double check between crew members before they enter close clearance hazards.

4. Revise the Conductor Training program ensuring that trainees will not be utilized as a Brakeman during training.[20]

5. Revise training programs to ensure that trainees are not qualified without approval from their assigned mentors.

To the Federal Railroad Administration ("FRA"):

1. Mandate that railroads implement a best practice hierarchy for providing protection of track centers and clearance-prohibited tracks.

2. Mandate a thorough training program for new hire conductors that will accommodate training within the entire territory.

3. Mandate a process that would require managers to review trainees for proper knowledge of close clearances, bulletin and timetable instructions and for proper demonstration of the application of such rules.

To the Association of American Railroads ("AAR"):

1. Recommend that your members implement a best practice hierarchy for providing protection of track centers and clearance-prohibited tracks.

2. Recommend that your members review and revise their Conductor Training programs, ensuring those trainees will not be utilized as a Brakeman during training.

[20] *See* Recommendations from DCA15FR013 Petal, Mississippi – NS Trainee incident.

CERTIFICATE OF SERVICE

I certify that on January 13, 2020 I have electronically served upon Mr. Troy Lloyd ([redacted]), Investigator in Charge, National Transportation Safety Board, a complete and accurate copy of these proposed findings regarding the February 7, 2019, switching fatality at Norfolk Southern Railway's Baltimore, Maryland, Bayview Yard (NTSB Docket No. RRD19FR004). An electronic copy of same was also forwarded to the individuals listed below in this certificate of service, as required by 49 CFR § 845.27 (Proposed Findings).

National Transportation Safety Board
c/o Mr. Troy Lloyd
Investigator in Charge, RRD19FR004
[redacted]

Mr. Kurt Erickson
Federal Railroad Administration
Deputy Regional Administrator
[redacted]

Mr. David Gooden
Norfolk Southern Railway
Division Superintendent
[redacted]

Mr. Jared Cassity
SMART Transportation Division
Investigator, National Safety Team
[redacted]

Sincerely yours,

[redacted]

Stephen J. Bruno
Brotherhood of Locomotive Engineers & Trainmen
National Secretary Treasurer
National Chairman, Safety Task Force
7061 East Pleasant Valley Road Independence, OH 44131

APPENDIX A

BALTIMORE CONSOLIDATED TERMINAL

5. COMMUNICATION INFORMATION (CONT.)

B. AAR RADIO CHANNELS

Base Station	Channel 1 TX and RX	Channel 2 TX (RX)
Remote Control Operations	050-050	N/A
Bayview Yardmaster	064-064	N/A
PBR (Sparrows Point)	007-049	032-032

C. TELEPHONE NUMBERS

Harrisburg Division OSS	800-898-4296
Mechanical Operations Center	404-582-6700 / 7-582-6700
LCDI Help Desk	7-981-4256
Bayview Yardmaster	410-558-1503
Amtrak CETC Section 2	215-349-2264

6. TERMINAL INSTRUCTIONS

A. CLOSE CLEARANCE

Account close clearance situations, employees are prohibited from riding the sides or end of equipment in the following locations:

1. Baltimore, MD (Bayview) - Close clearance exists on #1, #2 and #3 Relay when cars are on adjacent tracks.
2. Baltimore, MD (Presidents Street I.T.) - Close clearance exists on the Incline Track, Bank Track or Perryville Above when cars are on adjacent tracks.
   Note: On Perryville Above, cars other than empty flat cars could strike equipment passing on Bank Track due to track profile.
3. Baltimore, MD (Presidents Street I.T.) - Close clearance exists on all tracks except the North Track on Eastern Ave. U.G. bridge due to girders adjacent to the tracks.
4. Amtrak NEC, MP 90.9 (Grasmick Lumber) - Close clearance exists at their facility due to their perimeter fence.
5. Amtrak NEC, MP 122.5 (Home Depot) - Close clearance exists at the main entrance due to a gate loading into the facility.

B. TRACK PERMISSION

1. SPARROW POINT I.T.

Movements en route to Bayview Yard from Sparrows Point I.T. must stop in the clear of the foul point of all tracks at River and receive permission from the Yardmaster at Bayview for yarding instructions. After permission is received, the route must be lined and double checked before movement is initiated.

2. LOCATION OF RUNNING TRACKS

Running Track	Between	Permission from	Restricted Speed not exceeding:
Bear Creek	Canton Jct. and End	Bayview Yardmaster	10 MPH

C. INTERLOCKING INSTRUCTIONS

NON INTERLOCKED RAILROAD CROSSING AT GRADE

Interlocking at Canton, where the Canton R.R. crosses the Bear Creek R.T. at Newkirk Street, all trains must stop clear of the crossing and communicate with Bayview Yardmaster for movement instructions.

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B: Safety Alert

February 12, 2019

On Thursday, February 7, 2019 at approximately 7:00 AM EST, Keith Gilmore, a 35-year-old Norfolk Southern Conductor died after sustaining injuries during a shove movement in Baltimore, MD. Mr. Gilmore was riding equipment, positioned on the side of a railcar on the leading end of a shove movement at the time of the accident. His body came into contact with standing equipment on an adjacent track, and he was subsequently struck by his movement. Norfolk Southern extends its deepest condolences to Mr. Gilmore's family, friends, and co-workers.

Incident Description

While the investigation of this tragic incident is still ongoing, the following information is known:

- Mr. Gilmore had been employed with Norfolk Southern for six (6) months.
- Mr. Gilmore was working as a conductor on assignment H63 in Bayview Yard.
- Mr. Gilmore was using the radio to communicate with his engineer to direct their shove movement.
- The yard tracks that H63 operated on at the time of the accident have close track centers.

Safety Considerations

***Although the cause of this accident is not yet known, safety considerations in this publication should be used to elevate awareness on how to work safely in the railroad environment*. Always pause to identify risks, process the information to choose a safe course of action, and proceed with the task in a safe manner.**

Applicable Rules For Discussion

Although the incident remains under investigation, a few rule excerpts are provided for review to minimize risks when operating on tracks restricted account close track centers and riding equipment.

- Participation and involvement in Job Safety Briefings are required and must be done:
  - At the beginning of each job
  - When the work changes
  - When the work becomes confusing or new tasks are started
  - When a rule violation is observed

  The person conducting the Job Safety Briefing must confirm that everyone involved understands all the instructions. ***Reference Operating Rule 1 Job Safety Briefings***

- Employees are prohibited from riding equipment on tracks designated by Special Instructions to be restricted account close track centers. NOTE: This rule does not prohibit an employee from riding on the platform of a locomotive in these tracks. ***Reference Operating Rule 20(a)(4) Prohibited Acts – Riding equipment on tracks restricted account close track centers***

- Some platforms, bridges, and other structures, switch stands, tunnels, and equipment on adjacent track will not clear a person on the top or side of a car or engine. Employees must become familiar with these and other close clearance locations and protect themselves from injury. ***Reference Operating Rule 27 Close Clearance***

What other material is available for review on shove moves?

- Operating Rule 216 Shoving, Backing, or Pushing Movements

EXCEPTION: Spiking or clamping, and applying a "Switch Out of Service" tag is not required for RWP protection provided switch is secured with an approved craft specific lock.

(c) Employees observing a switch that needs to be used but is locked and identified as "Out of Service' must not operate the switch and must contact the proper authority for further instructions.

185. Double Checking Switch or Derail Position

When radio communication is used in connection with switching operations, or with the shoving, backing, or pushing of a train, engine, or other On-Track equipment:

(a) The employee directing the movement must advise the Engineer or RCO of the track name or number and that all switches and derails are properly lined for the intended move.

(b) The Engineer will repeat this information and require the employee to "double check" the position of the switches and derails.

The Engineer must not begin the movement until confirmation is received from the employee directing the movement that the position of the switches and derails has been "double checked."

186. Lining and Locking Switches and Derails After Use

Switches and derails must be properly lined and secured after having been used.

NOTE: Locks must be tested to assure that they are secured. If a lock is defective or missing, the switch or derail must be secured if practical and report must be made at first opportunity to the Control Station or other proper authority.

187. Operating Over a Switch

Switches must not be operated while engines, cars or On-Track equipment are fouling the switch, or standing or moving over the switch.