



Norfolk Southern Railway Company

Party Submission

**Reed, PA
RRD22LR003**

(7 pages)

**Party Submission of Norfolk Southern Railway Company in Response to
Various Draft Reports of the National Transportation Safety Board, Office of
Railroad, Pipeline and Hazardous Materials Investigations**

In Re:

**Fatality Involving Kolton Helbert, a non-employee, occurring on December 8,
2021 on Norfolk Southern Railway's Buffalo Line Near Reed, Pennsylvania**

I. INTRODUCTION

Kolton Helbert, an employee of National Salvage Corporation, was fatality injured on December 8, 2021, on the Buffalo Line of Norfolk Southern Railway Company (Norfolk Southern) near Reed, Dauphin County, Pennsylvania. The accident occurred at approximately 11:24 a.m. Members of the National Transportation Safety Board and others conducted an investigation of the incident and have submitted, to date, four draft reports consisting of 1) Mechanical Group Factual Report, 2) System Safety Factual Report, 3) Survival Factors Report, and 4) Track and Engineering Factual Report.

This submission is presented by Norfolk Southern in response to some of the preliminary findings of the NTSB contained within those reports. Norfolk Southern had previously submitted objections, suggested revisions and additions to those reports from Joseph Young, Manager Program Maintenance-North of Norfolk Southern. This submission is filed as a supplement to those responses.¹

II. NORFOLK SOUTHERN ADDRESSES THREE MAIN AREAS OF CONCERN WITH THE DRAFT REPORTS SUBMITTED BY THE NTSB.

a. Walking conditions within the right-of-way at the time of the accident were not a cause of this accident.

The Survival Factors Draft Report, pages 13-14, and in particular lines 299-302, contains Section 4.1 entitled “Walking Conditions.” Within this section there is an observation made by the author that the area between the main track and the siding had “piles of debris containing used spikes, anchors and other track material. The presence of the material created a potential

¹ Norfolk Southern conducted its own investigation of the circumstances surrounding the accident at issue involving Mr. Helbert. It reserves the right to challenge or correct any of the findings of the NTSB which are not supported by facts of record or are contrary to the findings of Norfolk Southern.

slip, trip or fall hazard.” There is an additional observation that to the west of the main track, the terrain fell away from the track also presenting a slip, trip or fall hazard. (Page 14, lines 301-303). The report goes on to address two unrelated accident investigations in Missouri and New Hampshire where it is alleged that “poor walking conditions” caused or contributed to the accident. (Page 14, lines 317-329.) Neither accident referred to bears any resemblance to the facts of this accident. Both involved operating personnel doing shove movements and switching operations into local industries. Neither accident cited involved rail replacement along a main line. The rail gang involved here was removing and installing 1,342 feet of continuously welded rail between mile post BR295 and BR295.25. NTSB Track and Engineering Draft Report, p. 4, lines 13-14. Replacement of rail which involves old rail removal and new rail replacement, requiring spiking operations, will appropriately involve loose spikes being located within the right-of-way during the replacement process. Survival Factors Draft Report dated April 14, 2022, p. 1, lines 24-25.

As the facts of this accident demonstrate, based upon the observations made by the NTSB itself, walking conditions played no part in the cause of the occurrence of this accident. To the contrary, the NTSB Track and Engineering Draft Report, p. 11, lines 14-15 specifically found that “the shoulder and crib ballast appeared to be adequate and clean with no obstructions.” More to the point, at the time of the accident, Mr. Helbert was seen standing within the gauge of the main track behind and in close proximity to Spiker No. 2. Survival Factors Draft Report dated April 14, 2022, p. 2, lines 29-30; System Safety Group Draft Factual Report dated June 7, 2022, p. 3, line 31. There is no information that any walking conditions in the vicinity of where the accident occurred caused or contributed in any manner to the accident.

As was further observed by the operator of Spiker 3, “behind” Spiker 2 who was quoted as indicating “he said that the contract worker was standing in the gauge.” System Safety Factual Draft Report dated June 7, 2022, p. 12, lines 15-16. The operator of Spiker No. 1 reported that he saw Mr. Helbert walking north (away from him) between the main and siding several minutes before the accident. He makes no mention of Mr. Helbert having any difficulty walking or encountering any debris or slip, trip or fall hazards. System Safety Factual Draft Report dated June 7, 2022, p. 9, lines 11-19.

As the above discussion illustrates, the accident occurred while Mr. Helbert was improperly standing within the gauge of the main track. There is no evidence that any “slip, trip or fall” hazard caused or contributed in any manner to his presence there or to the accident. In fact, there is direct testimony that Mr. Helbert was walking within the six-foot between the main track in the main and siding without any difficulty minutes prior to the accident.

b. The ability to contact emergency medical assistance (911) did not cause or contribute to the accident or to the injuries or death of Mr. Helbert.

The Survival Factors Draft Report dated April 14, 2022, contains a Section 5 entitled “Emergency Response,” pp. 15-22. This section primarily concerns the initial and subsequent contacts with first responders to enable them to access the scene of the accident and render aid. The section discusses some initial difficulty by the first caller to contact 911 being able to provide a GPS mappable location for the emergency responders. There is also a discussion of the need for responding EMS vehicles to travel back along a “rustic access road” which slowed arrival to the actual accident scene. The report also contains numerous interviews with several of the first responders. Survival Factors Draft Report dated April 14, 2022, p. 17, lines 388-392. There is also an observation that it was decided to shut down the adjoining highway to enhance

accessibility. However, the report eventually concludes these factors were not a cause of the death of Mr. Helbert. Survival Factors Draft Report dated April 14, 2022, p. 15, lines 392-395.

It must be remembered that the accident involved Mr. Helbert becoming trapped underneath a large heavy piece of equipment. The evidence shows that the railroad workers present moved promptly to lift the equipment using a crane onsite to allow access to Mr. Helbert and his eventual extraction from within the gauge underneath the machine. Survival Factors Draft Report dated April 14, 2022, p. 19, lines 443-446. The EMTs that arrived were directed to the scene without delay by railroad workers. Survival Factors Draft Report dated April 14, 2022, p. 21, lines 482-483, 490-491.

There is no indication that the slight delay in confirming the accident location to 911 caused or contributed to the occurrence of the accident or any subsequent injuries to or death of Mr. Helbert. There is no evidence that Mr. Helbert was conscious at any time after the initial impact or that his death was caused by any slight delay in accessing him, particularly when considering the nature of his entrapment under a heavy piece of equipment that needed to be lifted by a crane.

c. The precise location of the impact has not been established.

Several of the reports reference a point of contact indicating the location where Mr. Helbert was struck by the spiker. NTSB Track and Engineering Draft Report, p. 12, lines 2, 12. It has not been conclusively determined where the precise point of impact occurred. A distance of 29 feet is also quoted in the various reports. For example, see System Safety Factual Draft Report dated June 7, 2022, p. 19, Diagram; NTSB Track and Engineering Draft Report, p. 12, line 2. As stated earlier the precise location of impact has yet to be determined. The operator of Spiker No. 3 stated that he saw Mr. Helbert immediately before the accident and that he was

standing in the gauge, facing east and appeared to be looking down. Track and Engineering Draft Report, p.6, lines 13-18. The operator further stated that Mr. Helbert was struck within a second or two of seeing him. Considering the relative speed of Spiker No. 2, it is highly questionable that he could have been standing 29+/-feet from the rear of the Spiker when it began moving in reverse to strike him in that short time period.

d. Mr. Helbert's presence within the gauge of the track and in close proximity to the rear of the spiker in violation of applicable safety rules was the cause of the accident and not any visibility issues.

The System Safety Factual Draft Report dated June 7, 2022, makes various visibility observations including charts located on pp.17-19. As the interviews of Norfolk Southern personnel demonstrated, the operator of Spiker No. 2, prior to reversing his move to assist Spiker No. 3 behind him, looked in his mirror, honked his horn and then proceeded to move in reverse. System Safety Factual Draft Report dated June 7, 2022, p. 11, lines 1-5. Thus, the decision of Mr. Helbert to place himself within the gauge of the track, a known safety violation, caused the accident and directly interfered with the ability of the operator of Spiker No. 2 to observe him due to the configuration of the machine and his location.

Respectfully submitted,



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Norfolk Southern Railway Company