National Transportation Safety Board

Office of Railroad, Pipeline and Hazardous Materials Washington, DC 20594



RRD23FR016

COMBINED FACTUAL

Group Chair's Factual Report December 12, 2023

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A. ACCIDENT

Location: Cumberland, Maryland Date: August 6, 2023 Time: 11:42 PM EDT 2:42 UTC Train 1: 113706

B. COMBINED FACTUAL GROUP

Group Chair / IIC	Michael Bachmeier NTSB NTSB IIC
Party Coordinator	Steve Ammons CSX Transportation Director of Train Handling Rules and Practices
Party Coordinator	David Wyatt Brotherhood of Locomotive Engineers and Trainmen Safety Task Force
Party Coordinator	Jared Cassity SMART-TD National Safety Team
Party Coordinator	Zachary Boone Maryland Department of Labor Track
Party Coordinator	Josh Quillen Federal Railroad Administration Operations IIC

C. SUMMARY

On Sunday, August 6th, 2023, the CSX train 113706 was called on duty in Baltimore, MD at 1700 hours. The crew consisted of one Engineer (EN), one Conductor (CO), and one Conductor Trainee (CT). The crew briefed over the phone with a yardmaster and assembled their train consisting of 2 locomotives and 3 intermodal cars at Seagirt Yard. The train was 728 feet in length.

After assembling their train and testing the train's braking system, the train departed in route to Cumberland, Maryland. The train arrived in Cumberland and received instructions to pick up 13 cars. The CO and CT Trainee dismounted the train and prepared to shove their train from Main Track No. 1 at Viaduct, to the Freight track, and then Track No. 2 to couple into the 13 additional cars.

During the shove movement, the CO was on the leading end of the movement and directing the shove with instructions to the EN. The CT mounted the same side of the equipment, one intermodal platform back on the next available side ladder. As the shove move progressed down the Freight track, the crew encountered three locomotives parked on the adjacent track known as the city track. While the conductor rode by the parked locomotives he looked back to check on his conductor trainee and noticed that CT had fallen off or was falling off the equipment. The CO radioed the EN and directed him to stop the movement. The CO responded to CT and found him in distress and immediately called for medical assistance.

The weather at the time of the incident was dark, 73.4° Fahrenheit, and no precipitation. The weather was recorded at the Greater Cumberland Regional Airport, 2 miles SW of the accident site.



Figure 1. Aerial view of accident location. (Google Earth)

D. TERRITORY

The Cumberland Terminal Subdivision extends from MP BA 173.3 to MP BA 179.7 with Cumberland Yard being MP BA 173.3 to BA 179.1. The subdivision is oriented in a timetable west to east direction and is contained in the Cumberland Terminal Subdivision timetable # 2.

The maximum authorized speed in Cumberland Yard is 20 mph and the speed on the Main Tracks at the point of impact are 25 mph. The speed for the Freight Track is 20 mph and the City Track speed being 10 mph.

The territory is generally undulating with rolling grades of +1.77% to -0.95%, with the grade at the accident location being ascending grade (+0.21%). The Freight Track going west is a compound curve, 1-degree curve transitioning to a 5-degree curve. On the City Track going west is a compound curve, 1-degree 30-minute curve transitioning to a 5-degree curve.

E. METHOD OF OPERATION

The Cumberland Terminal Subdivision is double main track with the yard situated on the subdivision. At the location of the accident, the method of operation is Movement on other than Main Track¹. Train movements are coordinated by a Yardmaster located in Cumberland Yard. The method of operation on the Main Tracks is Train Control System (TCS) and are governed by a train dispatcher in Jacksonville, Florida. Positive Train Control (PTC) is active on the controlled tracks of the Cumberland Terminal Subdivision in the accident location.

F. INTERVIEWS

The investigative team interviewed six CSX employees (Conductor, Engineer, two Manager of Train Operations, Track Supervisor and the New Hire Mentor) on Tuesday, August 8, 2023, and Wednesday, August 9, 2023, at the CSX Cumberland Terminal Office in Cumberland, Maryland. Also, the team interviewed a seventh employee (REDI Center Instructor for Conductors) virtually and he participated from the CSX REDI Center in Atlanta, GA on August 23, 2023.

Please refer to the docket for the full interview transcripts².

G. SEQUENCE OF EVENTS

On August 8, 2023, the investigative group conducted a review of the forward facing from the standing locomotives and security footage from a local business. The following was developed based on the group's observations:

1.0 Local business (car lot across the street)

Footage shows rear of train entering from the right-hand side with the conductor riding the side of equipment. Riding position is inconclusive for the conductor and CT. Position of conductor appears to be lower than that of the CT. Movement occurs seconds before the CT disappears behind the car and a light is

¹ Movement on other than main track "definition": Except when moving on a main track or on a track where a block system is in effect, trains or engines must move at a speed that allows them to stop within half the range of vision short of train, engine, railroad car, men or equipment fouling the track, stop signal, or derail or switch lined improperly

² The full interviews are located in the docket at this web address: <u>NTSB Docket - Docket Management</u> <u>System</u>

seen on the ground under the train. Audio can be heard of screams following the incident.

2.0 CSXT 934 (trailing unit of train I137-06 facing east)

- At 23:35:02 the train observed moving in a west direction to pull past the viaduct signal off main track 1. Train stopped when rear of train was west of the signal. CO and CT are seen coming around the rear of the train from the north side walking to the south side of right of way.
- At 23:38:02 the CO was observed mounting the rear car on the south side of DTTX 790238. At 23:38:03 the CT was observed mounting on the same side of DTTX 790238 of the other end in view of the conductor.
- At 23:38:57 the shove move was observed going into the freight track. Both the conductor and CT are seen on the side of the car by looking at their lanterns.

3.0 CSXT 901 (facing east on the city track)

- At 23:42:06 the rear car comes into view going past but cannot see the conductor.
- At 23:42:12 the CT light was seen shining on the very end of the container in the well of the car he is riding.

4.0 CSXT 3328, (the middle unit on the city track facing east)

• At 23:42:16 the group observed what appeared to be the first contact of CSXT 3160 by the rocking motion. Audio was also heard at this time of the CT in distress calling for help.

5.0 CSXT 3160 (the east locomotive facing east)

- At 23:42:20 the rear of train 113706 was observed going by with the CO riding the rear and first hear the CT calling for help. The CO is heard telling EN on radio stop, stop, stop and then you can see train stop.
- At 23:43:06 the conductor could be seen walking towards the CT and you can hear CT calling for help. The CO is then seen walking faster.

6.0 Audio only

Audio was heard from two of the 3 locomotives that were sitting on the city tracks, CSXT 3328 and CSXT 3160. Also, radio communication between the CO and EN were reviewed.

- 23:38:33- The CO was talking to the EN giving instructions that he and the CT were in the clear riding the shove and had a restricting signal and to come back 15 cars.
- 23:41:13- CO was heard telling EN come back another 20 cars.

H. LOCOMOTIVE/IMAGE RECORDER TIMELINES

On August 8, 2023, the investigative group conducted a review of the forwardfacing video and event recorder data from the lead locomotive CSXT 583. The following timeline was developed based on the group's observations:

- o 23:38:57 Start of shoving movement, notch 1 immediately into notch 2
- o 23:40:26 back to notch 1
- o 23:40:24 Minimum service reduction applied, 825' traveled, 8.1 mph, throttle 2
- o 23:40:42 Begins throttle modulating, 1,012', 5.8 mph
- o Speed fluctuates between 6-9.5 mph while throttle modulating between notch 1 and 2
- o 23:42:03 notch 2, 8 mph
- o 23:42:23 Full-service application applied, 9.5 mph, 2,071' traveled
- o 23:42:29 Brake cylinder pressure applied, possible independent brake application
- o 23:42:41 Equipped reached stop, 0 mph, 2,238'

Summary of event recorder download key events, air is set to minimum reduction once bunched, power braking into the movement, indicates a move being made with people riding the rear. Once desired speed is reached, the throttle modulates between notch 1 and 2 before applying a full-service brake, then applying the independent when the movement stops. The operations group did not note any erratic or abnormal manipulations of the operating controls during the review of the event recorder data. The group found that the train handling methods utilized by the engineer prior to the accident were found to be consistent with normal operations for the type of equipment and circumstances.



Figure 2. Snapshot of event recorder data during shoving movement.

I. TRACK

At the point of impact on the Cumberland Terminal Subdivision Main Track 1 and Main Track 2 are FRA Class 2 track with a maximum timetable speed of 25 mph. The Freight track is FRA Class 2 track with a maximum timetable speed of 20 mph. The City Track is FRA Class 1 track with a maximum timetable speed of 10 mph.

7.0 Track Details

The Freight Track, near the point of impact, is constructed with 6-inch by 8-inch timber cross ties. The crossties measured 8-feet 6-inches long and spaced 18-inch to 24-inch centers (nominal). The crossties are supported with standard 14-inch double shoulder steel tie plates with conventional 6-inch cut track spikes as fasteners to secure gage. Spike pattern for the running rails consisted of two rail holding spikes on the gage side of the rails, one rail holding spike on the field side of the rails, and an additional hold down spike added on the field side. Crossties were box-anchored every other crosstie. The track is supported by #2 ballast of crushed stone of standard size measuring 1 ½ to 2 ½ inches in diameter. The running rail through the derailment area is 132 RE CC Continuous Welded Rail (CWR) rolled in December of 1948.

CSX's records show that the last inspection conducted by a CSX inspector was completed on the day of the accident, August 6, 2023. This inspection showed no

defects around the point of impact on any track. There was one defect noted at MP BA 158.0 for loose, worn, or missing switch clips.

8.0 Point of Collision

The investigation team determined that the point of impact (POI) was near MP BA178.76 on the Freight Track. The train traveled about 275 feet east after impact.

9.0 FRA Post-Accident Inspection

On August 8, 2023, the Federal Railroad Administration (FRA) conducted a post-accident inspection of the track in the area of the impact. This inspection included Main Track 1, the Freight Track, and the City Track. FRA took measurements of two (one on the high rail and one on the low rail) profile concerns 209' west of the point of impact on the Freight Track. The north rail profile measurement was 1/4" and the south rail measurement was 1-1/8". FRA noted no non-class-specific defective conditions or class-specific defective conditions.

In addition to the inspection, FRA took track notes (crosslevel, gage, and alignment), at 15 stations 15'6" apart before and after the point of impact. Also, FRA took track center measurements between the City Track/Freight Track and Freight Track/Main 2 at all 31 stations. At the point of impact FRA noted 1" of crosslevel (towards the City Track), 56-3/8" gage, and 1-1/8" alignment on the Freight track with 1/8" crosslevel (away from the Freight Track), 56-1/2" gage, 1-3/4" alignment on the City Track, and track centerline measured 11' 3-3/4" between the City and Freight tracks.

10.0 Close Clearance Types

Close clearance is a permanent or temporary situation where an obstruction near a railroad track physically impedes a person who is riding the side of a train from clearing the obstruction. A permanent close clearance is where the obstruction is fixed object and non-movable (i.e., a building, platforms). A temporary close clearance is one that is movable, not fixed, or only temporarily in place (i.e., any form of railroad rolling stock, rubber tired vehicle next to the track).

11.0 Close Clearance Requirements for Track Centers

CSX has track centerline requirements that applies to all new construction, reconstruction, and alterations of tracks. They have no centerline requirements for pre-existing track that has not been reconstructed or altered. Additionally, CSX has no requirements surrounding advance notification of close track centerlines.

The state of Maryland Regs. 09.12.91.04 - Clearance Requirements states:

F. Clearance Between Parallel Tracks.

(1) Except as otherwise provided in this regulation, the minimum distance between the centerlines of parallel track shall be as follows:

(a) Two parallel main tracks --- 4 feet;

(b) Yard and sidetracks --- 13 feet, 6 inches;

(c) Track other than main or passing track, which is parallel to main or passing track --- 15 feet;

(d) Where passing track is at least 15 feet from main track, other track adjacent to passing track --- 13 feet, 6 inches;

(e) Two parallel ladder tracks --- 19 feet;

(f) Ladder track parallel to other track --- 18 feet;

(g) Team, house, and industry track --- 13 feet;

(2) Tracks constructed before July 28, 1953, may be extended without increasing distances between tracks.

G. Other Conditions and Obstructions Adjacent to Tracks.

(1) Merchandise, material, or other articles may not be permitted to remain adjacent to any track at a distance less than 8 feet 6 inches from the centerline of track.

(2) A line or other marker shall be maintained at a distance of 8 feet 6 inches from the centerline of track, on all platforms except passenger platforms, to indicate the space which shall be kept clear.

(3) The space between tracks ordinarily used as a walkway by train and yardmen and other employees in the discharge of their duties, and the space beside those tracks within 8 feet 6 inches of the centerline of track, shall be kept in a reasonably suitable condition for that purpose.

H. Compliance. Except as provided in this regulation, a railroad company may not operate or permit to be operated any car, train, locomotive, or other equipment over its own tracks, or industrial tracks directly or indirectly connected with its own tracks, if: (1) Overhead or side clearances or clearances between tracks are less than the minimum prescribed in this regulation; and

(2) After July 28, 1953, tracks or structures adjacent to tracks are constructed or reconstructed by:

(a) The railroad company; or

(b) Others, if the railroad company has the right to control the construction or reconstruction.

The state of Maryland has no reports written for the last three years that have a defect or comment written on clearance requirements for track centerlines. The state of Maryland has no requirements for advance notification of close track centerlines.

FRA has no regulations on clearance requirements for track centerlines, nor the advance notification of close track centerlines. FRA has regulations surrounding leaving rolling and on track maintenance-of-way equipment in the clear (CFR 218.101).

J. MECHANICAL

12.0 Inspections

12.1 Pre-Departure Inspection

A class 1 brake test and pre-departure inspection was conducted at the initial terminal at 12:54 p.m. on August 6, 2023. The air-brake test was done in compliance with federal regulations. Documentation of the air test recorded brake pipe leakage of 1 psi.

12.2 FRA Post-Accident Inspections

FRA conducted a post-accident inspection of the equipment involved in the accident. FRA's Mechanical Inspector recorded eight defective conditions on Form FRA F 6180.96 Report Number 129, dated August 7, 2023. The conditions found in this inspection included four occurrences of (232.136) insufficient clearance of freight car handholds and one occurrence of (231.136) freight car handhold bent outwards. FRA took no exception to the initial Class 1 brake test conducted at the origin terminal.

Post accident measurements taken by the NTSB on scene indicated about 7 inches of clearance between train 113706 and the standing locomotives.



Figure 3: Clearance between the intermodal car and standing locomotives. (Photo: CSX.)

13.0 Train Consist

13.1 Freight Track (I13706)

The shoving train consisted of back-to-back locomotives and three intermodal cars: CSX 583 (lead locomotive), CSX 934 (trailing locomotive), DTTX 680155 (single pack), TTAX 556644 (5-pack), DTTX 790238 (3-pack) west to east. The conductor was riding the leading end of the shove move on the east pack of DDTX 790238 and the conductor trainee (deceased) was riding the leading end of the second pack of DTTX 790238. The train was 728 feet in length and weighed 305 tons.

13.2 City Track

On the City Track were three unoccupied facing east locomotives: CSXT 901, CSXT 3328, and CSXT 3160 (west to east).

K. NTSB POST-ACCIDENT SITE VISITS

The NTSB made site visit to the CSX REDI Center in Atlanta, Georgia on October 24, 2023. The trip included six NTSB investigators. The NTSB observed two different classes, one class was in week one of the REDI Center training, and the other class was in week five of the training. Additionally, the NTSB observed training conductors taking the four-minute railroad car ladder test, mount/dismount railroad cars, use hand signals to control train movements while riding the side of a railcar, and the use of a radio to control train movements while riding a railcar.

The NTSB made a site visit to Cumberland, Maryland after the REDI Center visit on November 7, 2023. Two NTSB investigators made the trip to discuss training with the two conductor mentors for Cumberland and the Operation Field Training Northeast Region Supervisor. The investigators also visited the site of the accident with the RFE and RFE Supervisor. The team noted the City Track was out of service.

L. OVERSIGHT AND CREW QUALIFICATIONS

CSX Transportation safety oversight is conducted through a written operations testing program developed by each railroad as required in title 49 Codified Federal Regulations (CFR) Section 217.9, Program of Operational Testing, and Inspections. This regulation requires that railroads have a written testing program and periodically conduct operational tests and inspections of their employees. These tests and inspections determine compliance with and reinforce expectations of operating rules, timetables, and special instructions.

As part of this investigation the operational tests conducted on the crews involved in this incident were reviewed. Employee records reflect the following testing was performed on the involved crews in the preceding 12 months:

Conductor- 27 tests entered with three failed tests and no tests associated with riding equipment.

Conductor Trainee- one test entered, and no tests associated with riding equipment.

Engineer- 74 tested entered with two failed tests and no tests associated with riding equipment.

The requirements for certification of engineers are contained in title 49 CFR part 240, Qualification and Certification of Locomotive Engineers. Within these requirements there are initial training requirements and recurring training that are needed for an engineer to stay current and qualified. As part of the investigation records were reviewed for the engineers pertaining to certification. In accordance with CSX rules the engineer was licensed, qualified and current to operate on the Cumberland Terminal Subdivision.

The requirements for certification of conductors are contained in title 49 CFR part 242, Qualification and Certification of Conductors. Within these requirements there are initial training requirements and recurring training that is needed for a conductor to stay current and qualified. As part of the investigation records were reviewed for the conductor pertaining to certification. In accordance with CSX rules the conductor was licensed, qualified and current to operate on the Cumberland Terminal Subdivision.

Operating crews are periodically tested on rules pertaining to their jobs. Training records were reviewed for both members of the I13706. Both crew members were tested on rules applicable to the accident and received passing scores on their last exams. The Conductor Trainee successfully passed all exams pertaining to training at the REDI center and was allowed to proceed to the second phase of Conductor training.

14.0 Crew Information

- CO hired Aug. 2022
- CT hire date 6/12/23
- CT Birth date 5/5/83
- CT height approximately 5'9", weight approximately 410 lbs.
- CT Orientation at terminal was 7/10/23
- CT first trip was 7/11/23
- CT 7/26/23 took the safety summit stand down for the CSX Baltimore Fatality

- CT June 26, 2022, injured leg (quad) while working out. This did not happen at the REDI Center. Employee wrote a statement.
- CT passed at the REDI on 6/30/23- 4 total minutes with 1 of the minutes giving assigned hand signals.
- CT had nothing documented on his RQS form.
- CT was at REDI 6/12/23 through 7/7/23.

M. APPLICABLE RULES

Rules that are applicable to riding on equipment.

15.0 CSX Safe Way Rule 2102.1

When riding on equipment, employees must:

- 1. Position body to face the equipment and look in the direction of travel,
- 2. Maintain 3-points of contact, keeping secure hand holds and footing,
- 3. Be prepared for unexpected movements and slack action at all times,

4. Ride the side of cars equipped with a horizontal grab iron at least 12 inches above the floor of the car or at least one vertical grab iron that allow an employee to stand upright.

5. Ride the side of rail cars or the trailing end of a cut of cars equipped with an end platform.

6. Ride the steps or front/rear locomotive platforms when positioned on the outside of a moving locomotive,

7. Dismount before passing a close clearance sign or reaching a close clearance,

8. Ride on the side of equipment away from live tracks, main tracks, sidings, close clearances, or other hazards, and

9. Dismount equipment prior to coupling.

Operating Rule Definitions: Close Clearance - A permanent or temporary object or structure that prevents the safe passage of an employee riding the side of the equipment. The employee operating the switch or derail is responsible for the position of the switch or derail in use. Movement must not foul an adjacent track until the hand-operated switch is properly lined.

16.0 Rule Books

At the time of the accident the following rule books were in effect on the CSX Cumberland Terminal Subdivision:

- CSX Employee Manual Effective February 1, 2023, which includes Operating Rules, Safe Way, Equipment Handling, Air Brake and Train Handling, and HazMat HM-1
- CSX System Bulleting Effective August 3, 2023
- CSX Subdivision Bulletin Effective July 1, 2023
- Cumberland Terminal Subdivision Timetable No.2. Effective November 1, 2019

N. SUBMITTED BY AND CHIEF REVIEW

Submitted by: Michael Bachmeier Investigator-In-Charge /s/ January 2, 2024

Approved by: Joe Gordon Branch Chief / RPH-120 /s/ January 2, 2024

O. PARTIES TO THE INVESTIGATION - ACKNOWLEDGEMENT SIGNATURES

The undersigned designated **Party to the Investigation** representatives attest that the information contained in this factual report for NTSB's accident investigation RRD23FR016 of the CSX Transportation fatality in Cumberland, Maryland is a factually accurate representation of the information collected during the investigation, to the extent of their best knowledge and contribution in this investigation.

Steve Ammons, CSX Transportation	Date /s/ 1/23/2024
David Wyatt, BLET	Date /s/ 1/23/2024
Jared Cassity, SMART-TD	Date /s/ 1/23/2024
Josh Quillen, FRA	Date /s/ 1/23/2024
Zachary Boone, MD Department of Labor	Date /s/ 1/23/2024

APPENDIX A

P. FRA SOFA ALERT

The following link will take you to an FRA SOFA Alert pertaining to this accident.

SOFA Alert - August 11, 2023 | FRA (dot.gov)

Q. CSX TRANSPORTATION INCIDENT ALERT

The following incident alert was issued by CSX after the accident.



Safety Briefing – Temporary Close Clearance

On August 6, 2023 a CSX trainee was fatally injured when he encountered a temporary close clearance while riding equipment in Cumberland, MD. This tragic incident remains under investigation and is a somber reminder that we must all remain focused and committed to maintaining situational awareness when performing critical activities.

Leaving equipment in the clear is a crucial part of our work process. Failure to comply with the requirements of leaving equipment in the clear can create unknown and/or hidden hazards that jeopardize the health and safety of other employees that may exist long after the equipment has been left. Considering the potential damage or severity of injury that improperly placed equipment can cause, it becomes clear that constant peer-to-peer communication regarding the location of equipment is necessary in order to safely execute our duties. Not only should these conversations occur between crew members, these conversations should occur between all affected personnel to ensure that all employees are apprised of changing conditions at a given location.

Although permanent close clearance locations may be identified by timetable and/or signage, situations or conditions that constitute a temporary close clearance may be more difficult to identify due to the dynamic nature of our work environment. As such, employees must know, and be familiar with, the locations in which they operate with regard to riding equipment. If employees are not familiar with the location, or are unsure if the positioning of equipment on an adjacent track might constitute a temporary close clearance condition - employees are empowered to stop, dismount, assess the condition and job brief accordingly. If a determination cannot be made, employees must take the safe course:

Taking the safest course of action means that we actively look to identify potential hazards and analyze the work environment in real time. We are empowered to make changes (ex: stop, slow down, reposition) to ensure the safest outcome for ourselves and our peers.



CSX Safety Department