



National Safety Team

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3/15/22

Mr. Ryan Frigo, Investigator in Charge
National Transportation Safety Board
490 L'Enfant Plaza East, S.W.
Washington, DC 20594

RE: Proposed Findings, Proposed Probable Cause(s) and Proposed Safety Recommendation(s) on behalf of SMART-Transportation Division as a result of the investigation into the March 3, 2021, BNSF Conductor fatality at Buena Park Yard in La Mirada, CA; NTSB Accident No. RR21FR008

Dear Mr. Frigo,

The SMART-Transportation Division National Safety Team would like to take this opportunity to thank the National Transportation Safety Board (NTSB) for granting our organization party status and the ability to participate in the investigation into the March 3, 2021, BNSF Conductor fatality at Buena Park Yard in La Mirada, CA; NTSB Accident No. RR21FR008 as part of the operations Committee.

After reviewing all the Committees' findings and reports, it is the position of SMART- Transportation Division that several contributing factors played a potential role in the loss of situational awareness in the BNSF Conductor fatality at Buena Park yard in La Mirada, CA on March 3, 2021.

Contributing Factors:

1. The factual report correctly states that only ambient light was present. The Buena Park Yard facility contains no fixed overhead lighting, as many other yards do. Most of the ambient light originated from a parallel location directly south of the portion of the train that had been left standing on track 6804, (the rear portion of which was run into). It was evident through site inspection that the cars left standing in track 6804 cast a shadow onto track 6803, the track being shoved at the east end of the yard. It was also evident that the gaps in the cars would allow the

ambient light through for a very short distance. As a result, while riding on the side of the car the conductor would travel into the shadow of the cars then see a short bit of ambient light then back into the shadows. This intermittent dark/light condition could clearly be disorienting, effecting the conductor's visibility as a result and depth perception. With the above-mentioned conditions, the fouling point would have been much harder to determine, because he would have been relying solely upon a handheld lantern.

2. The clearance point markers lacked any reflective quality that would have made them easier to identify or locate in the dark and shadowed conditions.
3. Through the crew interviews it was ascertained that the work performed by this train had been work assigned to a regular assigned job. The regular assigned crew had consisted of a conductor, brakeman, and engineer. The additional crew member would have negated the requirement of riding on the side of the car to protect the shoving movement by placing one crew member on the ground to receive the shoving movement.

Proposed recommendations:

1. Identify areas where crews are required to be on the ground or where regular switching operations occur and install railroad provided overhead lighting.
2. Install high visibility, reflective clearance markers in all areas where crew are required to perform regular switching operations.
3. Identify opportunities where providing an additional crew member would eliminate the need for riding on the side of a car for extended shoving movements

