

## Opening Statement

Good morning and welcome to the Boardroom of the National Transportation Safety Board.

I am Robert Sumwalt, and I'm honored to serve as the Chairman of the NTSB. Joining us today are my colleagues on the Board, Member Earl Weener and Member Bella Dinh-Zarr.

Today, we meet in open session, as required by the Government in the Sunshine Act, to consider the fatal collision of two freight trains in Roswell, New Mexico, on April 28, 2015.

A freight train struck an unoccupied standing train at 32 mph, not on the main track, but on a siding. The engineer and the conductor in the striking train both jumped from the train before impact, severely injuring the conductor, and, tragically, killing the engineer.

My colleagues and I want to offer our sincerest condolences to the loved ones of the engineer, and we hope that the conductor is on the way to the fullest possible recovery. Please understand that the sole purpose of our discussions today is to learn from this collision to prevent similar tragedies in the future.

This accident involved the use of a manual switch on mainline track in dark, or un signaled, territory.

The conductor of the standing train manually turned a switch to line a main track to a siding. The crew then moved their train to the siding. But the conductor did not turn the switch again for normal main track movement. So, trains on the main track would not continue on the main track, but rather, would divert into the siding.

Railroad workers turn such switches commonly in un signaled territories across the country. The system relies on each worker performing the task correctly. But, as history has shown from this accident and many others, from time to time, sooner or later, somebody will commit an error while performing this safety-critical task.

The people and the places change, but the same fault remains: The system relies on fallible humans behaving infallibly.

After the departure of the standing train's crew, the striking train arrived. Its crew had been told the switch was in the proper position. There was nothing to warn them that it was not.

The result was tragic.

Today we'll discuss technology that can protect against such mistakes – no matter what leads to them.

We'll also discuss another scourge of transportation safety – although there's no evidence that it contributed to the accident.

Namely, impairment. The active ingredient in marijuana was found in the blood of the striking train's engineer.

We cannot tell whether the engineer was impaired at the time of the accident, but there are Federal safety regulations that prohibit safety-sensitive railroad employees from using such drugs.

Finally, this brings me to the topic of what we don't know: the timing of the engineer's drug use. Since there was no inward-facing image recorder on the striking train, we have no time-stamped image of a crew member smoking marijuana.

Just as importantly, such a recorder might have alerted the railroad to the use of drugs on board its train. More broadly, an inward-facing video recorder would help the railroad detect or deter **any** prohibited behavior.

Today, the NTSB staff will briefly present the most pertinent facts and analysis found in the draft report. Our public docket, available at [www.nts.gov](http://www.nts.gov), contains over 500 pages of additional information, including photos, interviews, and inspection records.

Staff have pursued all avenues in order to propose findings, a probable cause, and recommendations to the Board. We on the Board will then question staff to ensure that the report, as adopted, truly provides the best opportunity to enhance safety.

Now Managing Director Dennis Jones, if you would kindly introduce the staff.

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