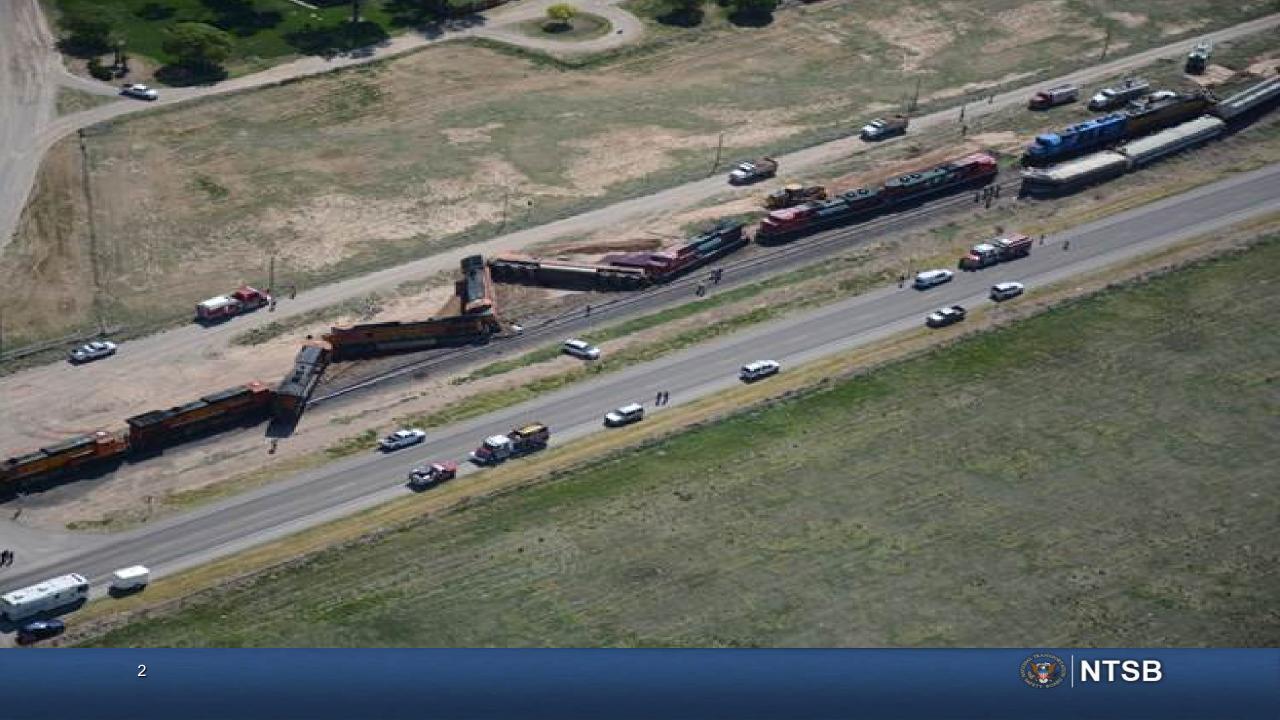


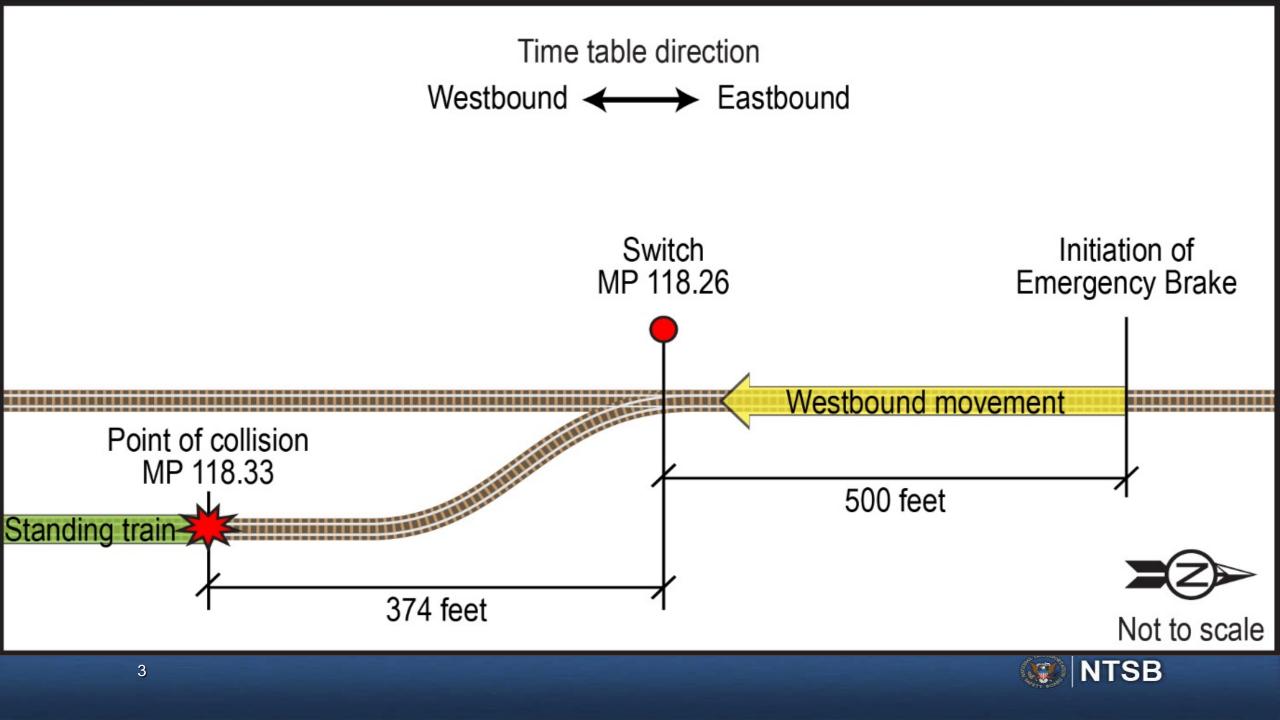
National Transportation Safety Board

Southwestern Railroad Collision Roswell, New Mexico April 28, 2015

Ted Turpin

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Parties to the Investigation

- Federal Railroad Administration
- Southwestern Railroad (No longer operating)
- New Mexico Public Regulation Commission



Safety Issues

• Switches in nonsignaled territory

Monitoring inappropriate crew behaviors



Switches in Nonsignaled Territory

Returning the switch to proper position
Currently - only procedures

2. Warning for approaching trains Small target or sign on switch



Drug Use - Striking Train Crew

- Engineer was positive for marijuana
- Conductor was positive for oxycodone
- Railroad could not monitor behaviors





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Title slide with NTSB 50th Anniversary Commemorative Emblem-Making Transportation Safer Yesterday, Today, Tomorrow. National Transportation Safety Board.



National Transportation Safety Board

Southwestern Railroad Collision Roswell, New Mexico April 28, 2015

Bob Beaton, Ph.D., CPE

Behavior of Striking Train Crew

Event recorder data shows the crew:

- Activated horn appropriately at highway-railroad grade crossings
- Maintained train steadily below track speed

Crew notified that switch was aligned to main line



Behavior of Striking Train Crew

On approach to switch:

- Initiated emergency braking 500 feet before switch
- Diverted into siding at 40 mph



Behavior of Striking Train Crew

On approach to standing train:

- Train traveled 374 feet and slowed to 32 mph at impact (6-8 sec)
- Crew jumped from locomotive before collision



Analysis of Striking Train Crew

- No inward-facing cameras
- Timely and appropriate actions to unexpected situation
- No behavioral signs of impairment



Ineffective Safety Devices

Switch banner is ineffective warning

- Passive flag is small visual target
- Similar issue in Bettendorf and Graniteville accidents



Behavior of Standing Train Crew

Work shift:

- Switched industry railcars
- Moved train into Chisum siding; no incidents
- Engineer set hand brakes on head-end locomotive
- Conductor collected end-of-train device



Behavior of Standing Train Crew

Conductor:

- Saw fuel truck
- Conversed with driver
- Picked up engineer
- Drove to hotel
- Failed to align switch as intended



Behavioral Analysis of Standing Train Crew

- Nature of human errors, such as errors of omission, are well-studied in human factors literature
- Routine procedural tasks are susceptible to error when people are interrupted – failure to resume procedure at proper step



Switch Alignment Failures

Failure to align manual switches is high-risk hazard in railroads:

- From 2008 to 2017, human caused accidents accounted for 37% of FRA reportable events, and failure to align switch accounted for 13% of those accidents
- Number 1 cause of FRA-reportable events (ex-grade crossings)





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