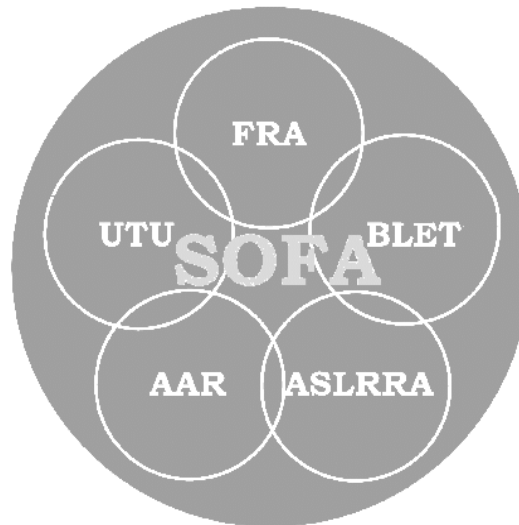


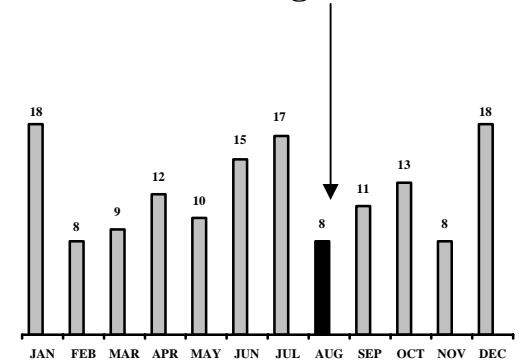
Please Post Immediately

*Make Switching Fatality Free:
Apply SOFA Operating Recommendations – Recognize Special Switching Hazards*

As of July 10, one Switching Fatality has occurred in 2006:
April 2, at Palmer, MI



Since 1992, 8 Switching Fatalities have occurred in August



August 2006 Switching Fatality and Severe Injury Update

(Feel free to use, reproduce, and circulate this information in your safety efforts.)

The Four Basic Facts about Switching Fatalities

Fact #1

Since 1992, on average, 10.4 Switching Fatalities occurred each year – one every 35 days. These tragic events are not random acts of nature.

Fact #2

Experienced railroad employees representing labor, management, and government have determined why Switching Fatalities occur.

Fact #3

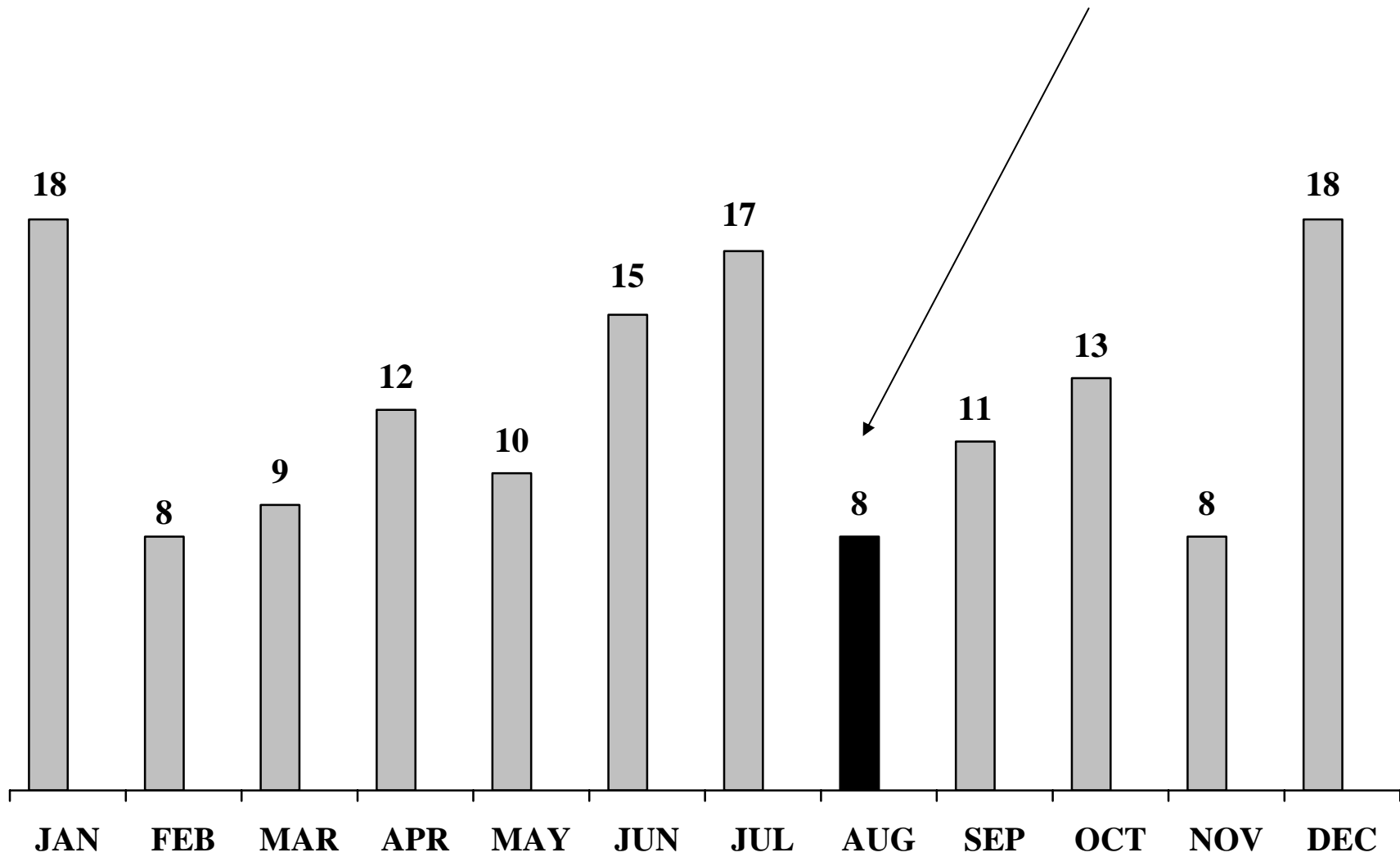
And have determined how Switching Fatalities can be prevented.

Fact #4

Knowledge about Switching Fatalities must be translated into action:

Apply SOFA Operating Recommendations–Recognize Special Switching Hazards

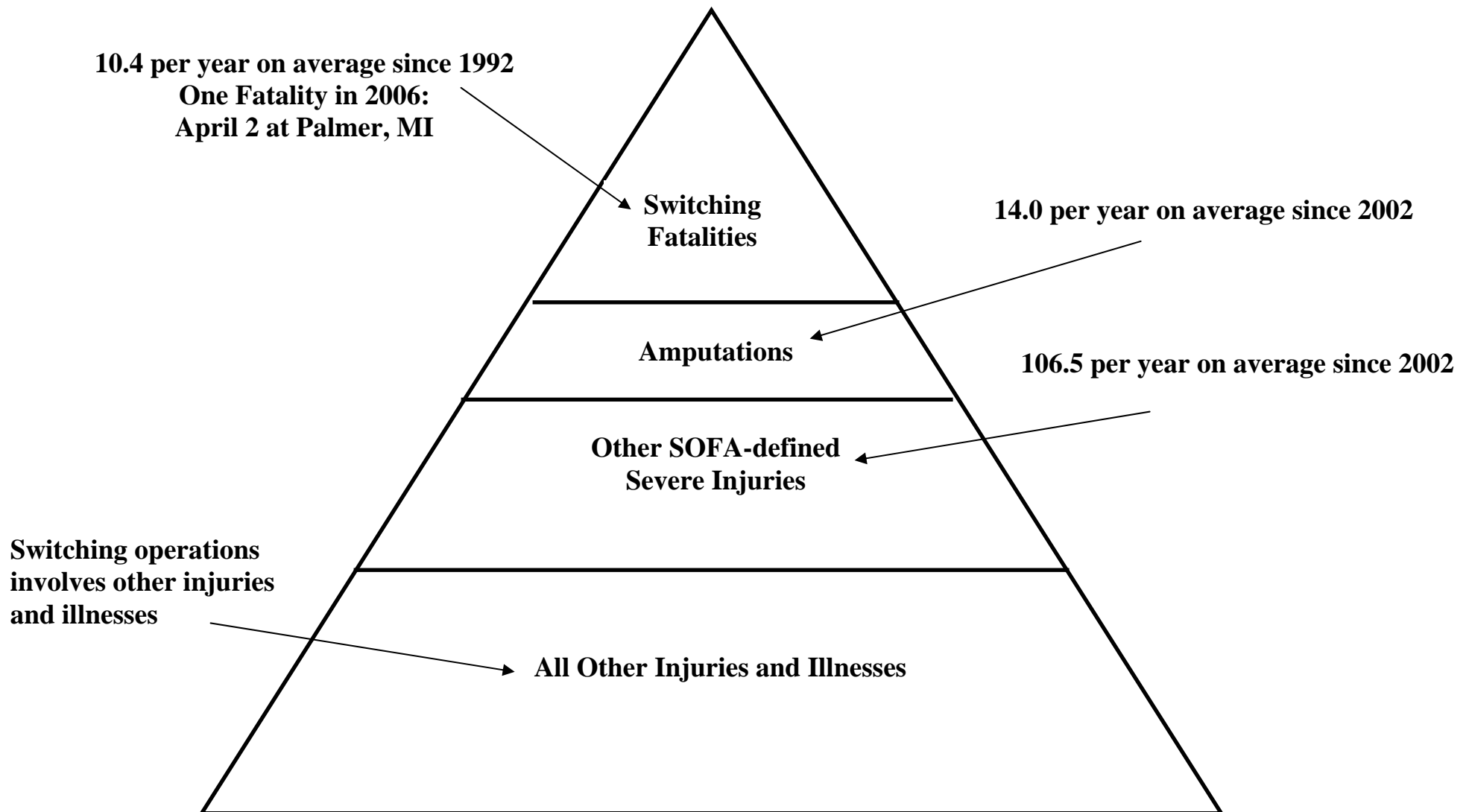
8 Of 147 Switching Fatalities in August since 1992



**10.4 Switching Fatalities occur on average each year
– a Switching Fatality every 35 days!**

Switching Operations Casualty Pyramid

Engaged in switching operations, an activity critical to the modern economy, railroad employees are exposed daily to risk of fatality, life-long disability, and injury and illness.

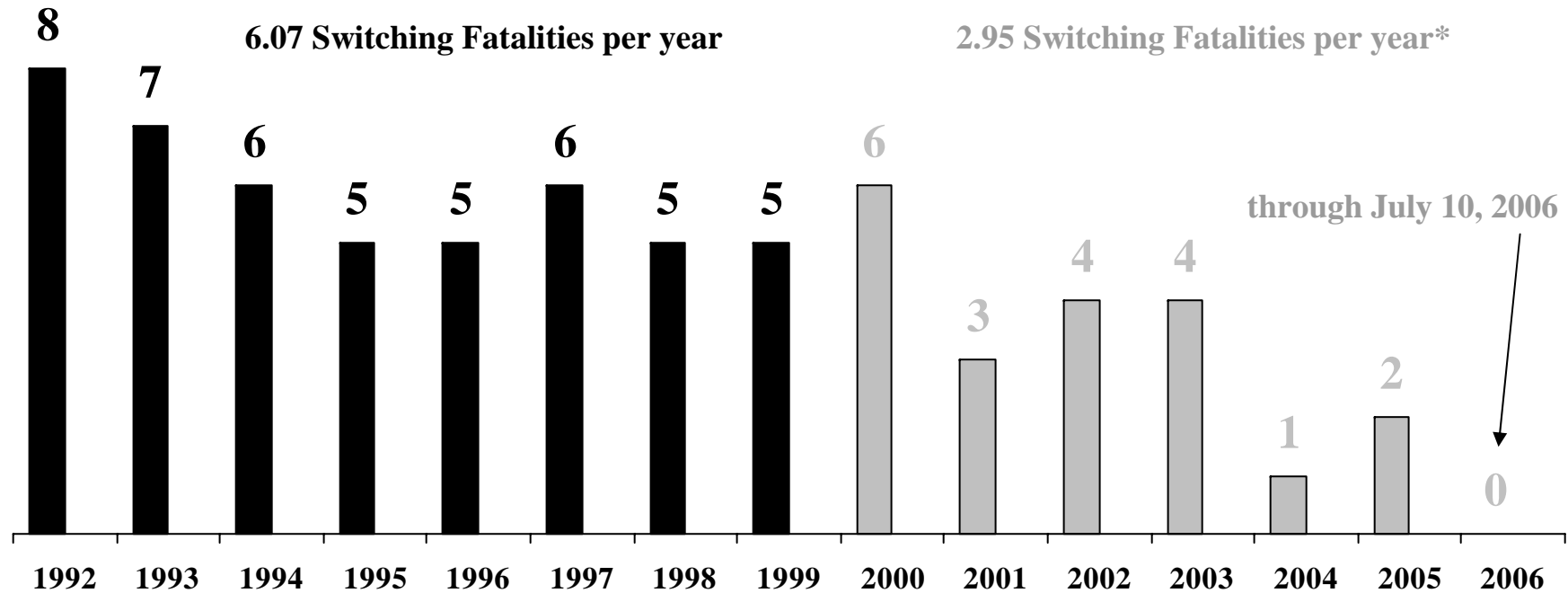


67 Switching Fatalities Related to SOFA Operating Recommendations

51 percent decline in yearly rate – 6.07 vs. 2.95 deaths per year

The original *SOFA Report*¹ was released in October 1999. Prior to the release, there were 47 Switching Fatalities related to the Five Operating Recommendations in the 7.75-year period January 1992 through September 1999. Expressed as a rate, there were 6.07 Switching Fatalities per year related to Operating Recommendations.

In the post-SOFA Report period of 6.79 years, October 1, 1999 through July 10, 2006, there were 20 Switching Fatalities related to the Five Operating Recommendations. Expressed as a rate, there were 2.95 Switching Fatalities per year* related to Operating Recommendations.

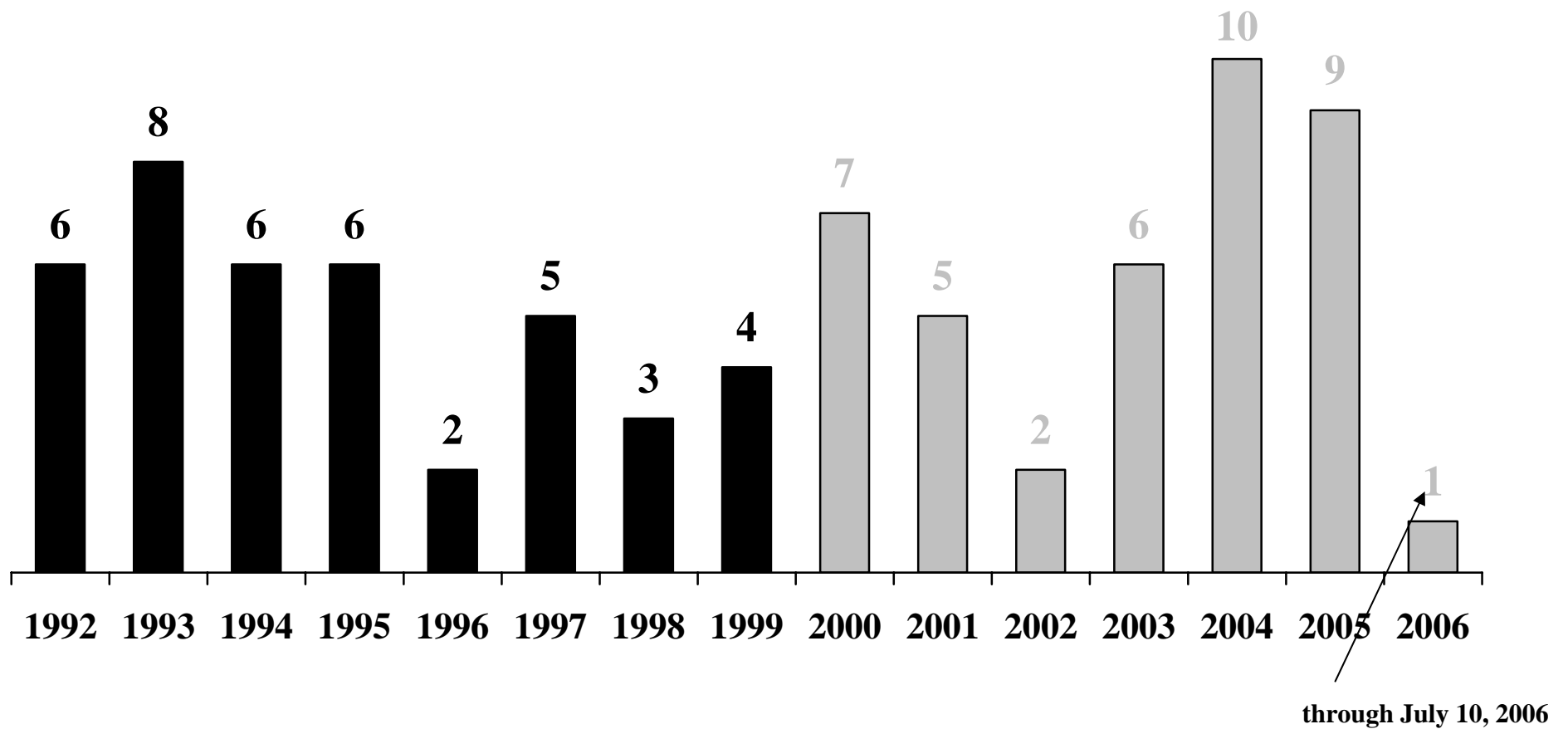


* The Switching Fatality at Burlington, IA, on December 4, 2005, is believed to involve a Close Clearance Special Switching Hazard. If further review by the SOFA Working Group determines one or more Operating Recommendations were involved, the Switching Fatality rate after the release of the *SOFA Report* would increase from 2.95 to 3.09.

¹ *Findings and Recommendations of the SOFA Working Group*. October 1999. Available at <http://www.fra.dot.gov/us/content/102>

80 Switching Fatalities Related to Special Switching Hazards

Recognize Special Switching Hazards



Recognize Special Switching Hazards

“In addition to the Five Operating Recommendations, the SWG (SOFA Working Group) wants to make those engaged in switching operations aware of Special Switching Hazards. In its review of each of the 124 fatalities, the SWG identified a number of fatalities involving close clearances (10 fatalities), being struck by mainline trains (8 fatalities), and occurring during shove movements (61 fatalities). The number of fatalities involving close clearance and being struck by mainline trains would be greater if those classified both as a Special Switching Hazard and an Operating Recommendation were included in these fatality counts.” — from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. p. xiv.

- Close Clearances*
- Free Rolling Railcars
- Exposure to Mainline Trains
- Tripping, Slipping, or Falling Exposures
- Adverse Environmental Conditions
- Shoving Movements
- Unsecured Cars
- Unexpected Movement of Cars
- Equipment Defects
- Motor Vehicles or Loading Devices
- Drugs and Alcohol
- Other Special Hazards or Events

* The SOFA Working Group has broadened the traditional definition of ‘close clearances’ to include situations “When an employee is passing, or being passed, by an object or equipment and the conditions are such that there is not enough room for the employee to avoid being struck.” From *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. p.48-50. Available at: <http://www.fra.dot.gov/us/content/102>

SOFA-defined Severe Injuries

January 1992 to April 2006

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	totals	average
JAN	11	13	16	15	21	12	11	11	20	10	140	13.9
FEB	17	15	9	9	9	13	17	14	10	6	119	12.0
MAR	14	12	17	11	10	10	13	10	9	8	114	11.8
APR	8	10	6	10	12	6	9	13	10	6	90	9.0
To date	50	50	48	45	52	41	50	48	49	30		46.3
MAY	6	12	8	8	12	14	9	6	6		81	9.0
JUN	9	10	8	11	8	5	10	9	7		77	.6
JUL	9	14	10	8	10	7	6	10	5		79	8.8
AUG	13	10	11	14	8	10	7	14	10		97	10.8
SEP	10	11	15	10	20	12	5	4	9		96	10.7
OCT	12	12	16	10	5	11	9	7	11		93	10.3
NOV	12	9	12	11	13	14	10	10	13		104	11.6
DEC	18	9	7	22	12	9	8	15	12		112	12.4
totals	139	137	135	139	140	123	114	123	122		1,202	

historically low

138.0 Severe Injuries occurred on average per year from 1997 through 2001

120.5 Severe Injuries occurred on average per year from 2002 through 2005

Severe Injuries are defined by the SOFA Working Group as (1) potentially life threatening; (2) high likelihood of permanent loss of function, permanent occupational limitation, or other permanent disability; (3) likely to result in significant work restrictions; and (4) result from a high-energy impact to the human body. 'Severe Injuries' include amputation, dislocation of the neck, loss of eye, electric shock or burn, and fracture to any bone except the lower arm, fingers, foot, and toes, See *Severe Injuries to Train and Engine Service Employees: Data Description and Injury Characteristics*. July 2001. Available at: <http://www.fra.dot.gov/us/content/102>

Amputations

A type of SOFA-defined Severe Injury

Amputations are shown separately because of the extreme trauma to employees engaged in switching, and the potential for permanent occupational limitations.

January 1992 to April 2006

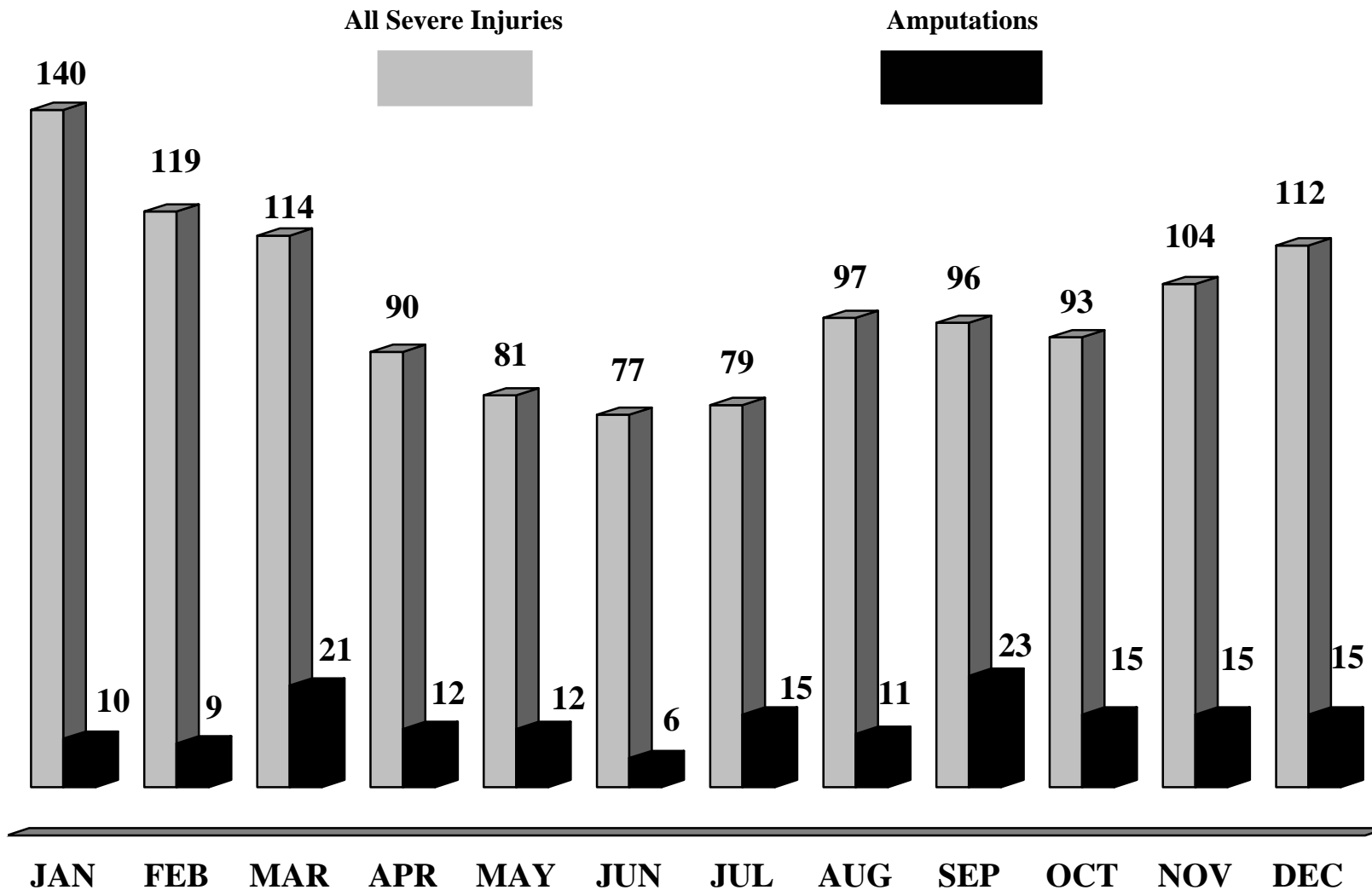
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	totals	average
JAN	1	0	2	1	0	0	2	2	2	0	10	1.0
FEB	0	1	0	1	0	2	1	2	0	2	9	1.0
MAR	3	4	3	2	1	1	3	1	2	1	21	2.2
APR	1	2	0	1	2	0	1	1	2	2	12	1.2
to date	5	7	5	5	3	3	7	6	6	5		5.2
MAY	1	2	3	0	2	2	2	0	0		12	1.3
JUN	2	1	1	0	1	0	0	1	0		6	0.7
JUL	1	5	1	0	4	0	1	2	1		15	1.7
AUG	1	0	1	4	0	1	0	2	2		11	1.2
SEP	2	4	3	2	5	4	0	0	3		23	2.6
OCT	2	5	2	2	0	0	2	2	0		15	1.7
NOV	2	2	2	2	3	0	1	1	2		15	1.7
DEC	4	1	0	4	1	1	2	1	1		15	1.7
totals	20	27	18	19	19	11	15	15	15		164	

20.6 Amputations occurred on average per year from 1997 through 2001

14.0 Amputations occurred on average per year from 2002 through 2005

Severe Injuries and Amputations by Month, January 1997 to April 2006

Amputations are a type of Severe Injury and are contained in the Severe Injury counts



8 August Switching Fatalities

#	Date	RR	Location	Age	Service (yrs)	Employee's Job	Employee Act	Employee Location	Fatal Event	SOFA Recommendations	Special Switching Hazard
1	08/04/93	UP	Pryor, OK	42	18	road brakemen	riding	on end of car	derailments		Close Clearance
2	08/11/93	SP	Tracy, CA	47	29	road brakemen	getting on	on end of car	struck by on-track equipment	3, 4	
3	08/12/93	ATSF	Evandale, TX	52	31	road brakemen	standing	on track	struck by on-track equipment	2	
4	08/15/97	UP	Elko, NV	53	28	yard brakeman	adjusting coupler	between cars/loc	sudden/unexpected movement of on-track equipment	1	
5	08/11/00	BNSF	Port of Los Angeles, CA	36	4	road brakemen	walking	on track	struck by on-track equipment	2	
6	08/08/02	CWRO	Cleveland, OH	53	34	yard conductor	riding	on side of car	struck against object	2	
7	08/26/03	LC	Chester, SC	29	4	road conductor	adjusting coupler	between cars/loc	sudden/unexpected movement of on-track equipment	1	
8	08/15/05	AM	Rogers, AR						To be reviewed by SOFA Working Group		

Apply SOFA Operating Recommendations – Recognize Special Switching Hazards

The SOFA Working Group

Comprised of union, management, and government representatives, the SOFA Working Group is trying to *Make Switching Fatality Free* through education and monthly dissemination of information on how Fatalities occur – and how such events, averaging 10.4 per year (a rate of one Fatality every 35 days), can be prevented.

August Switching Fatalities

Note: The Switching Fatality narrative summaries are taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. All other information is from the SOFA Matrix, the SOFA Working Group's electronic database.

No. 1 of 8: August 04, 1993 – UP – Pryor, OK

A three-person industrial switching crew was shoving three cars down a track. The conductor was on the ground, ahead of the move and the brakeman was riding the side of the leading end of the leading car. A bush created a clearance issue and the brakeman stepped around the side of the leading car to the end of the car just as it began to derail. The brakeman was killed when he fell from the derauling car.

Special Switching Hazard(s):

Possible Contributing Factor:

Possible Contributing Factor:

Possible Contributing Factor:

Close Clearance

Worn rail

Close or no clearance

Employee falling from moving equipment

Day of Week:

Wednesday

Time of Fatal Event:

4:45 PM

Time on Duty (hours: minutes):

6:45

Direction of Movement:

shoved

Crew's Next Move:

couple

Death Result of Train Movement?

yes

Other Movements Nearby?

no

Track Type:

inspection/stub track

Hit by Own Equipment?

yes

Striking Train Within Rules?

yes

Speed of Equipment (mph):

6

Crew Size:

3

Drugs Present?

no

Drugs a Factor?

no

Emergency Response Procedures Followed?

yes

August Switching Fatalities

Note: The Switching Fatality narrative summaries are taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. All other information is from the SOFA Matrix, the SOFA Working Group's electronic database.

No. 2 of 17: August 11, 1993 – SP – Tracy, CA

Crew performing industry switching. Brakeman attempted to couple air hoses while conductor gave engineer instructions to shove the movement. Resulting movement was unexpected to brakeman who was fatally injured.

SOFA Operating Recommendation(s):

Possible Contributing Factor:	3, 4
Possible Contributing Factor:	Poor intra-crew communication about work in progress
Possible Contributing Factor:	Hand signal, failure to comply
Possible Contributing Factor:	Other body defects (car)
External Circumstances:	Poor crew utilization

Day of Week:	Wednesday
Time of Fatal Event:	11:52 AM
Time on Duty (hours: minutes):	2:52
Direction of Movement:	shoved
Crew's Next Move:	shove to yard
Death Result of Train Movement?	yes
Track Type:	lead/industrial
Hit by Own Equipment?	yes
Striking Train Within Rules?	no
Speed of Equipment (mph):	5
Deceased Regular Job?	no
Had Deceased Worked There Before?	yes
Crew Size:	5
Drugs Present?	no
Drugs a Factor?	no
Emergency Response Procedures Followed?	yes

August Switching Fatalities

Note: The Switching Fatality narrative summaries are taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. All other information is from the SOFA Matrix, the SOFA Working Group's electronic database.

No. 3 of 8: August 12, 1993 – ATSF – Evandale, TX

Upon detraining, brakeman was struck and killed by another railroad's yard job working in the same small yard. Members of both crews saw each other but the brakeman apparently did not see the short line crews shove move.

SOFA Operating Recommendation(s):	2
Possible Contributing Factor:	Employee on or fouling track
External Circumstances:	Failure to communicate unsafe condition
Day of Week:	Thursday
Time of Fatal Event:	1:25 PM
Time on Duty (hours: minutes):	3:25
Temperature (Fahrenheit):	100
Direction of Movement:	shoved
Crew's Next Move:	make cut
Death Result of Train Movement?	yes
Other Movements Nearby?	yes
Track Type:	siding/industrial
Hit by Own Equipment?	no
Striking Train Within Rules?	no
Speed of Equipment (mph):	5
Crew Size:	3
Drugs Present?	no
Drugs a Factor?	no
Emergency Response Procedures Followed?	yes

August Switching Fatalities

Note: The Switching Fatality narrative summaries are taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. All other information is from the SOFA Matrix, the SOFA Working Group's electronic database.

No. 4 of 8: August 15, 1997 – UP – Elko, NV

Crew was switching in class yard. Helper was attempting to adjust the drawbar in order to couple to three cars about forty feet away that had not coupled the first time. While adjusting the drawbar, the helper did not notice the three free-rolling cars coming back in on him and the cars coupled him up.

SOFA Operating Recommendation(s):

Possible Contributing Factor:

Possible Contributing Factor:

External Circumstances:

1

Failure to apply handbrakes on car(s)

Employee on or fouling track

Yard track grade

Day of Week:

Friday

Time of Fatal Event:

3:30 AM

Time on Duty (hours: minutes):

3:31

Temperature (Fahrenheit):

65

Direction of Movement:

free-running

Crew's Next Move:

couple track

Death Result of Train Movement?

no

Track Type:

yard/flat/classification

Hit by Own Equipment?

yes

Speed of Equipment (mph):

1

Deceased Regular Job?

yes

Had Deceased Worked There Before?

no

Crew Size:

3

Emergency Response Procedures Followed?

yes

August Switching Fatalities

Note: The Switching Fatality narrative summaries are taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. All other information is from the SOFA Matrix, the SOFA Working Group's electronic database.

No. 5 of 8: August 11, 2000 – BNSF – Port of Los Angeles, CA

Employee was struck and killed by the lead car of another switching movement that was operating on the adjacent yard track.

SOFA Operating Recommendation(s):	2
Possible Contributing Factor:	Failure to communicate unsafe condition
Possible Contributing Factor:	Shoving movement, absence of a man on or at leading end of movement
Possible Contributing Factor:	Employee on or fouling track
Possible Contributing Factor:	Poor inter-crew communications
External Circumstances:	Joint operations
Day of Week:	Friday
Time of Fatal Event:	10:50 PM
Time on Duty (hours: minutes):	7:50
Temperature (Fahrenheit):	65
Direction of Movement:	shoved
Crew's Next Move:	shove drag
Death Result of Train Movement?	yes
Other Movements Nearby?	yes
Track Type:	yard/flat/lead
Hit by Own Equipment?	no
Striking Train Within Rules?	no
Speed of Equipment (mph):	7
Deceased Regular Job?	yes
Crew Size:	3
Drugs Present?	no
Drugs a Factor?	no
Emergency Response Procedures Followed?	yes

August Switching Fatalities

Note: The Switching Fatality narrative summaries are taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. All other information is from the SOFA Matrix, the SOFA Working Group's electronic database.

No. 6 of 8: August 08, 2002 – CWRO – Cleveland, OH

A two-person crew was switching cars in a yard and, without the trainman's knowledge, another switching crew had set cars into a track adjacent to the one being used by the first crew. The set out included a wide ladle car and it created a clearance issue on the adjacent track. Some time later, the trainman was riding the lead car down the track adjacent to the wide ladle car and was killed when he was rolled between the car he was riding and the wide ladle car sitting on the adjacent track.

SOFA Operating Recommendation(s):	2
Possible Contributing Factor:	Close or no clearance
Possible Contributing Factor:	Failure to communicate unsafe condition
Possible Contributing Factor:	Poor inter-crew communications
External Circumstances:	Other body defects (car)
Day of Week:	Thursday
Time of Fatal Event:	4:15 AM
Time on Duty (hours: minutes):	5:15
Temperature (Fahrenheit):	65
Direction of Movement:	shoved
Crew's Next Move:	spot
Death Result of Train Movement?	yes
Other Movements Nearby?	no
Track Type:	yard/industrial/spot(load/unload)/outside
Hit by Own Equipment?	yes
Speed of Equipment (mph):	2
Deceased Regular Job?	yes
Crew Size:	2
Drugs Present?	no
Drugs a Factor?	no
Emergency Response Procedures Followed?	yes

August Switching Fatalities

Note: The Switching Fatality narrative summaries are taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. All other information is from the SOFA Matrix, the SOFA Working Group's electronic database.

No. 7 of 8: August 26, 2003 – LC – Chester, SC

A three-person crew that included a brakeman trainee was switching an industry when the conductor requested a short backup move when the cars he intended to couple to did not couple. A short time later and after failed attempts to contact the conductor the trainee discovered him dead and lying between the cars he had been trying to couple together.

SOFA Operating Recommendation(s):

Possible Contributing Factor:	1
Possible Contributing Factor:	Employee on or fouling track
Possible Contributing Factor:	Failure to provide adequate space between equipment
Possible Contributing Factor:	Other miscellaneous causes
Possible Contributing Factor:	Coupler mismatch, high/low
External Circumstances:	Radio communication, improper

Day of Week:	Tuesday
Time of Fatal Event:	12:30 PM
Time on Duty (hours: minutes):	5:00
Temperature (Fahrenheit):	89
Direction of Movement:	shoved
Crew's Next Move:	couple
Death Result of Train Movement?	yes
Other Movements Nearby?	no
Track Type:	lead/industrial
Hit by Own Equipment?	yes
Striking Train Within Rules?	yes
Speed of Equipment (mph):	1
Deceased Regular Job?	yes
Crew Size:	3
Drugs Present?	no
Drugs a Factor?	no
Emergency Response Procedures Followed?	yes

August Switching Fatalities

Note: The Switching Fatality narrative summaries are taken from *Findings and Recommendations of the SOFA Working Group: August 2004 Update*. All other information is from the SOFA Matrix, the SOFA Working Group's electronic database.

No. 8 of 8: August 08, 2005– AM – Rogers, AR

An Arkansas & Missouri Railroad Company (AM) brakeman was directing a car to a spot within a plant when he was crushed to death between the car and a close clearance structure.

(To be reviewed by SOFA Working Group)

The Five Lifesavers

(based on SOFA Working Group Recommendations)

- Secure equipment before action is taken
- Protect employees against moving equipment
- Discuss safety at the beginning of a job or when a project changes
- Communicate before action is taken
- Mentor less experienced employees to perform service safely