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Safety took a back seat at Amtrak, feds say. Then workers died

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WASHINGTON — Federal authorities lambasted Amtrak Tuesday, blaming a failed culture that put punctuality ahead of safety for the deaths of two workers in [Chester last year](#).

“Despite the emphasis on rules compliance, investigators did not find a culture of compliance at all. Rather, they found a culture of fear, on one hand, and normalization of deviance from the rules on the other,” Robert Sumwalt, chairman of the National Transportation Safety Board, said at a hearing reviewing the investigation of the crash.

On April 3, 2016, Amtrak train 89 struck a backhoe on an adjacent track while traveling 99 mph. Two veteran Amtrak employees — the backhoe operator, Joe Carter, and a supervisor, Peter Adamovich — were killed. Thirty-nine passengers were injured on the train of eight passenger cars, a cafe car, and a baggage car traveling from New York City to Savannah, Ga. It carried seven crew members and 337 passengers.

NTSB investigators found 20 separate [safety lapses](#) that contributed to the crash. Amtrak had proper safety procedures in place, they said, but workers weren’t following them and there was little effective oversight.

“I don’t ever recall seeing an accident with 20 different prevention factors,” said Earl Weener, a member of the NTSB board. “It’s generally more like three or four.”

At Tuesday’s hearing, the federal agency singled out Amtrak, but also the Federal Railroad Administration (FRA) and rail worker unions for contributing to conditions that made the fatal derailment possible.

Amtrak responded through a memo issued to workers that detailed nine initiatives begun since the crash to improve safety.

“Our customers expect us to operate safely, and our jobs and lives depend on it,” said the statement issued jointly by Amtrak’s two chief executives, Wick Moorman and Richard Anderson. “We can and will do better.”

The Chester crash also highlighted the limits of Positive Train Control, an automatic braking system designed to prevent crashes on the rails. That system would have prevented a 2015 Amtrak derailment in Philadelphia that killed eight. It is now in place on all Amtrak-owned track on the Northeast Corridor, but in the Chester crash, human error undermined the system’s effectiveness. That prompted some members of the NTSB board to recommend more technology be deployed on the railroads to make PTC more effective.

“We need to take proactive steps to make sure railway workers stop dying,” said T. Bella Dinh-Zarr, an NTSB board member.

The derailment happened about 7:50 a.m., shortly after a shift change on a rail cleaning project. The NTSB singled out both the night foreman, [William Robinson](#), and the day foreman, John Yager, for failing to ensure trains wouldn’t travel on tracks where workers would be present. Even though there were still workers on the tracks, Robinson canceled safety protections, known as foul time, when he ended his shift, the NTSB found. Yager, meanwhile, never contacted a dispatcher to restore those protections when he began his shift. The day foreman also failed to give workers a proper safety briefing before they began work, as is required.

The dispatcher, meanwhile, had been told by the night foreman that the day foreman would be requesting foul time, but the dispatcher never followed up when he didn’t hear from Yager. The dispatcher, Michael Franklin, was making personal phone calls in the minutes before the derailment, investigators found.

Robinson was fired this year. Amtrak could not say what the status of Yager and Franklin are with the company.

“The large takeaway is that the system is broken culturally and structurally,” said Tom Kline, who is representing Carter’s family in ongoing litigation against Amtrak in connection with the crash. “They finally said there’s something really wrong that really needs to be fixed.”

“To a large degree it’s a vindication of my client and the unfair way he has been managed,” said Mark Schwartz, who is representing Robinson.

The mistakes happened in the context of larger systemic failures, the NTSB found. It had become a standard shortcut for foremen to cancel and resume foul times while maintenance equipment was still on the tracks, which violated proper procedure, Sumwalt said.

Amtrak failed to issue foremen shunts, a device required by Amtrak’s own procedures that alter the electrical current running through tracks to alert a dispatcher to the presence of workers on the rails.

The two men killed in the crash, as well as the train's engineer, all had drugs in their system. That didn't appear to contribute to the crash, NTSB officials said, but was further evidence of major failures in Amtrak's oversight.

Amtrak workers operated under a safety program so punitive they at times looked the other way at safety failures rather than report problems, according to the NTSB review.

Amtrak's managers, meanwhile, made no effort to ensure shunts were being used by work crews, had no rules preventing dispatchers from making personal phone calls while on the job, and had no procedures to ensure trains slowed when they approached areas where workers were present.

"They emphasized on-time performance over safety," said Dr. Nick Hoepf, one of the investigators.

The NTSB recommended Amtrak improve oversight for dispatchers and work crews on the tracks and ensure shunting devices are being used. It also recommended Amtrak impose speed restrictions on trains passing through areas where workers are on the tracks.

Since the 2016 crash, Amtrak bought shunts for workers. In the memo sent to workers Tuesday, Amtrak described making changes to its manual for workers on the rails, revising safety training courses and expanding drug and alcohol testing to include rail workers, who previously weren't included in Amtrak's random testing. The national rail carrier also has restructured its safety, compliance, and training programs into one department to improve coordination; hired a new vice president to run that department; and increased communication with workers on safety issues.

Some of the issues cited by the NTSB haven't changed, though. Unions along the Northeast Corridor opted out of two safety programs through contract negotiations, NTSB officials said, and an adversarial relationship between labor leaders and management continues. A more cooperative relationship between workers and management was among the NTSB recommendations.

"I think it's inexcusable for either of these parties, or any of these parties, to have allowed safety to become a labor management contract negotiating issue," Sumwalt said.

Jed Dodd, who leads the union that represents rail-repair workers in Pennsylvania, agreed that Amtrak had a failed safety culture. He said the most recent initiatives, which included workers watching each other for safety failures and a process for reporting close calls due to safety failures, put all the onus on workers.

"It's always the employee's fault," he said.

The NTSB also called out the FRA, recommending it require railroads to submit safety programs, specifically making devices like shunts mandatory for workers on the railroad. The FRA would review the NTSB recommendations, a spokesman said.

Amid the pointed criticism of Amtrak during the nearly four-hour hearing, board member Dinh-Zarr focused on the failures this crash revealed about PTC. Because the dispatcher had not logged foul time, and because shunts were not in place, the PTC system could not detect the presence of workers on the track.

Dinh-Zarr prompted an additional recommendation for the FRA that pieces of equipment used for maintenance, like the backhoe involved in this crash, be outfitted with technology that would identify those vehicles to a PTC system as obstacles on a track. All passenger railroads are federally mandated to have PTC installed by the end of 2018.

“It could have been prevented,” Dinh-Zarr said. “Two people are dead today because of human circumvention of the PTC system.”