

New Guidance for CAST: Case Study of a US Freight Rail Stop Signal Overrun & Collision

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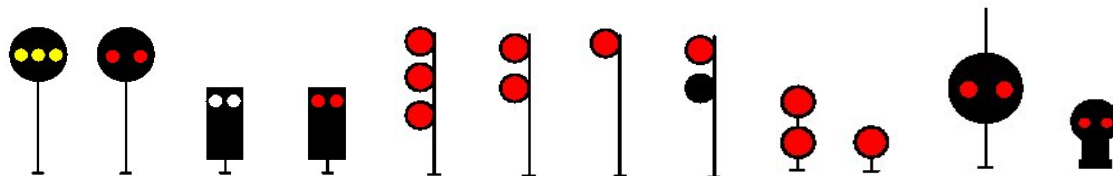
A photograph of a railroad crossing. In the foreground, several sets of railroad tracks run parallel, receding into the distance. Above the tracks, a metal structure supports three pairs of red signal lights. A sign on the structure reads "E NAPERVILLE". The background shows green trees and a clear sky. A semi-transparent red box is overlaid on the right side of the image, containing white text.

Objectives & Background

New CAST Guidance
Freight Rail Case Study
Discussion

Objectives

- ❑ Apply CAST to a freight rail case study in order to understand systemic causes of stop signal overruns
- ❑ Suggest additional guidance for CAST to help analysts understand which types of information to include

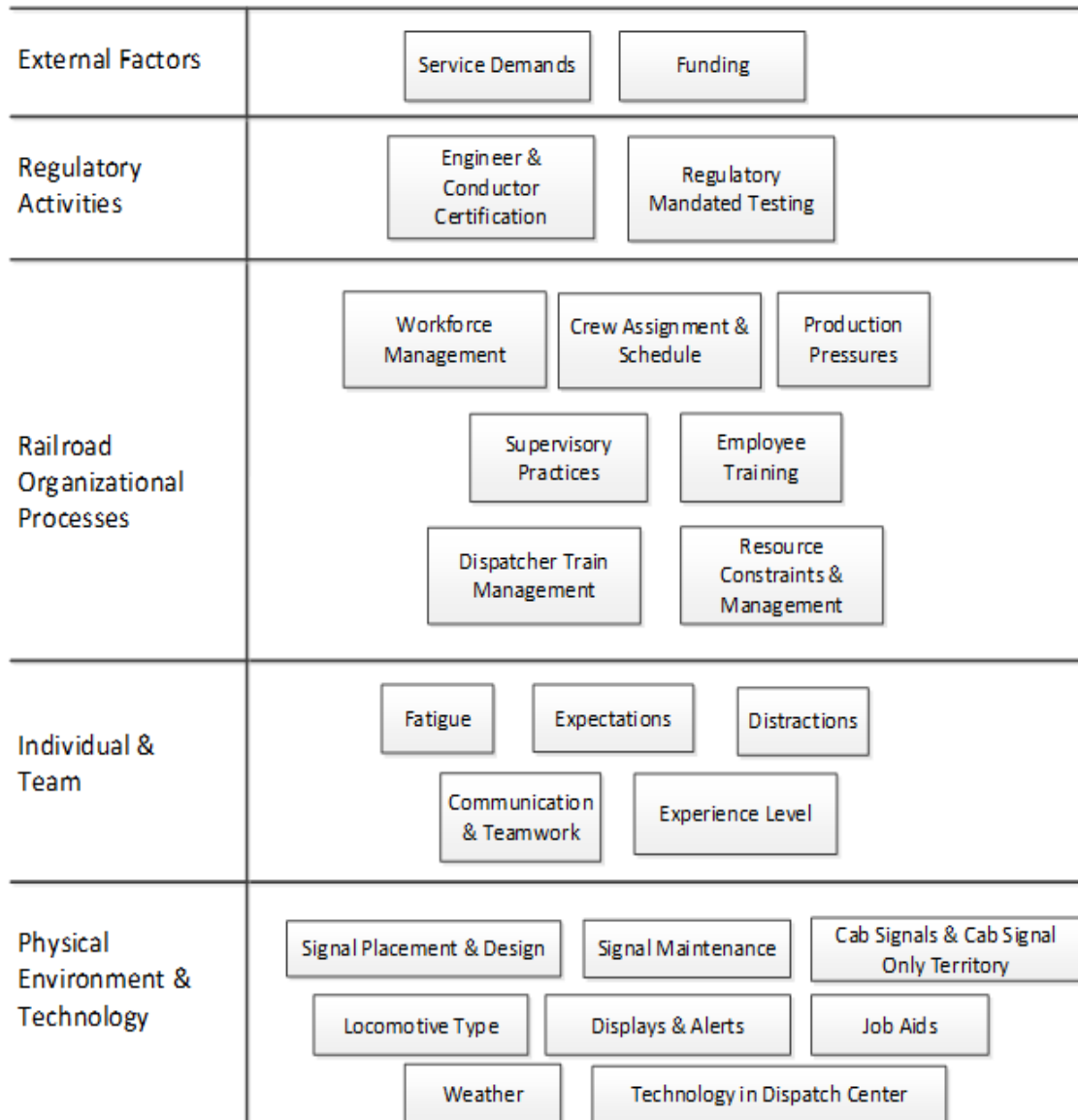


Background: Stop Signal Overruns (SSOs)




- ❑ Consequences can include derailment or collision; may result in injuries, fatalities, and major property damage
- ❑ Railroads tend to blame the operators (engineer, conductor), but many factors contribute to these incidents!

Background: Stop Signal Overruns (SSOs)



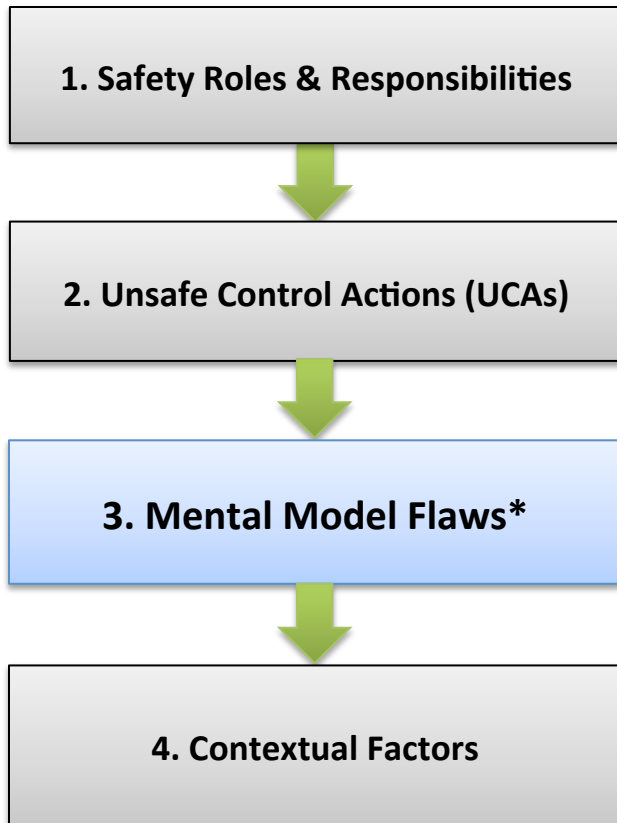
- ❑ 2 prior studies at passenger railroads examining SSOs
- ❑ Focus groups, interviews, and observations
- ❑ Identified contributing factors at all levels of the system hierarchy!

(Safar, Multer & Roth, 2017)

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Additional Guidance: Mental Model Flaws

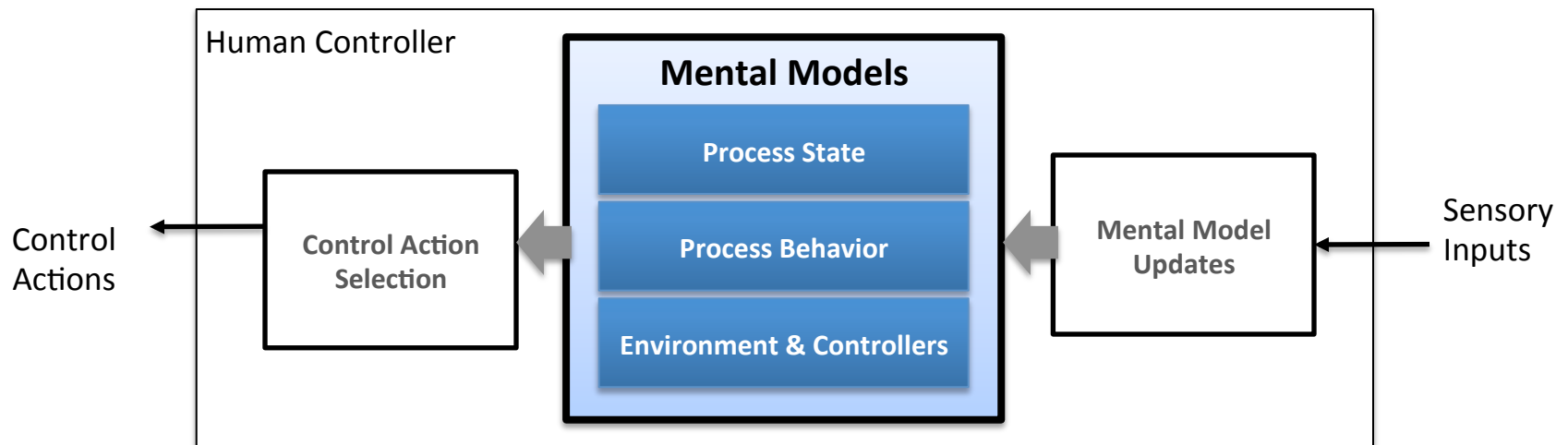


Recent work (France, 2017) provided additional guidance for mental model flaws in STPA; can be applied to CAST

*This presentation uses *mental model* in place of *process model* when referring to human controllers.

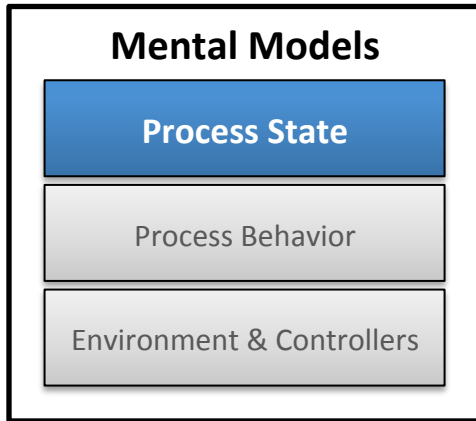
Foundation of Mental Model Guidance

STPA – Engineering for Humans Extension



(Thomas & France, 2016; France, 2017)

Guidance for Mental Models

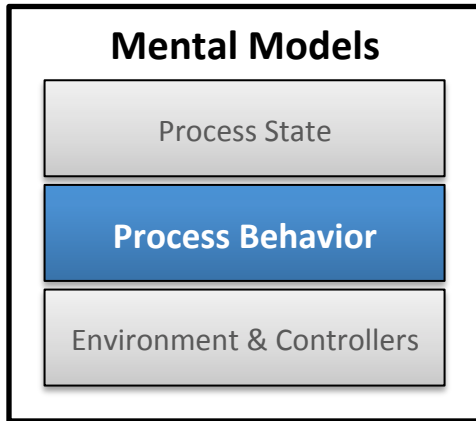


Mental Model of Process State

- ❑ Beliefs about modes and mode changes
- ❑ Beliefs about the current process stage (for processes with multiple stages)
- ❑ Beliefs about system variables (e.g. true/false, on/off)

(France, 2017)

Guidance for Mental Models

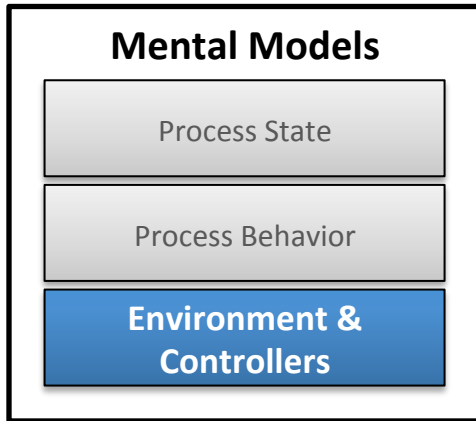


Mental Model of Process Behavior

- ❑ Beliefs about what the system can do
- ❑ Beliefs about how the system will behave in a particular mode or process stage
- ❑ Beliefs about if-then relationships between operator input and system output

(France, 2017)

Guidance for Mental Models

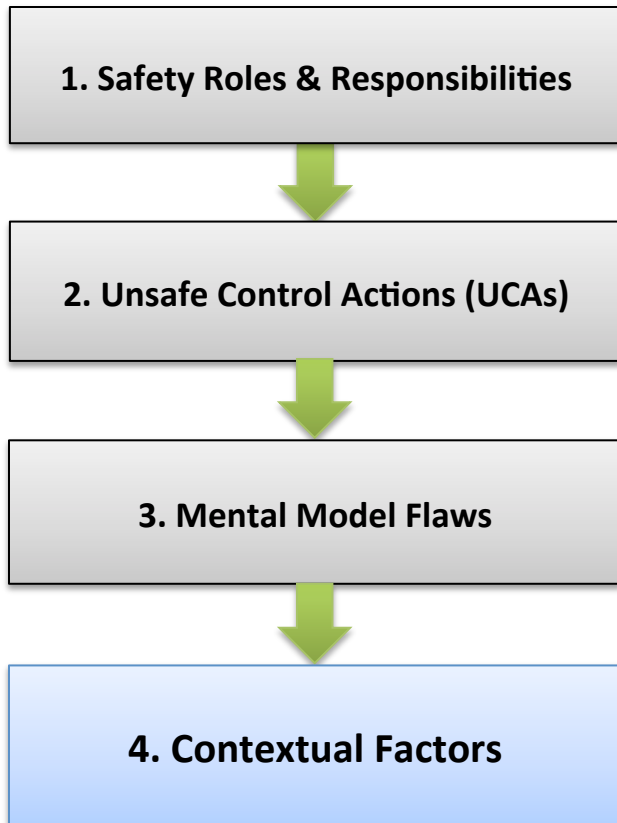


Mental Model of Environment & Controllers

- ❑ Changes to environmental conditions
- ❑ Familiar or unfamiliar environments
- ❑ Other controllers' states and behaviors
- ❑ Social and organizational factors

(France, 2017)

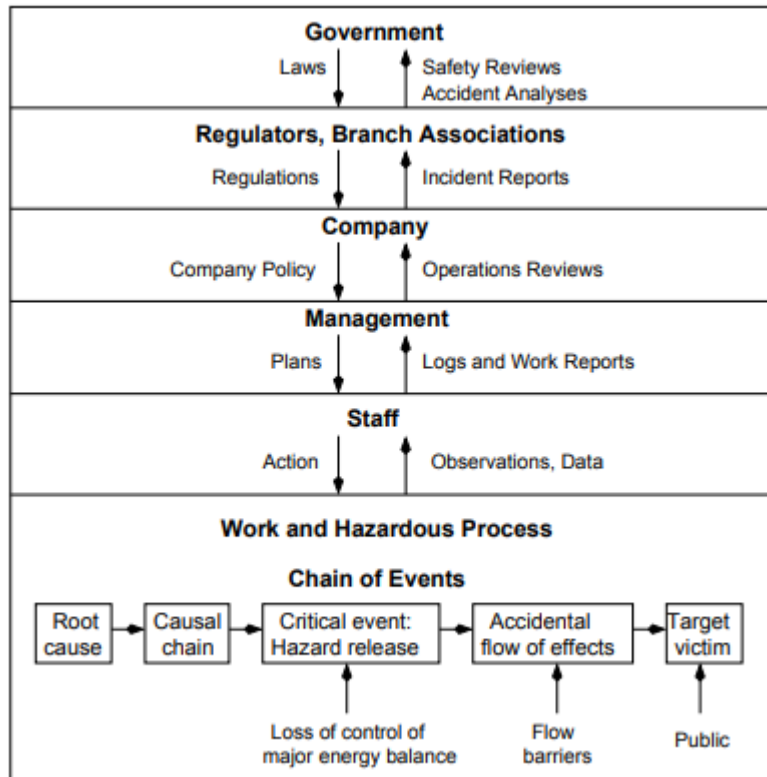
Additional Guidance: Contextual Factors



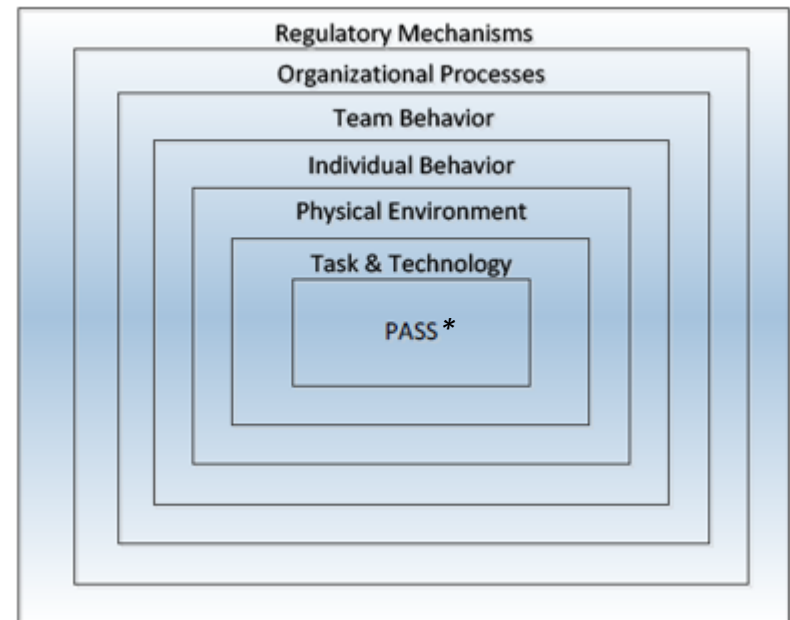
Contextual factors is a broad category, leaving analysts with potential questions:

- ❑ Which types of information belong in “contextual factors”?
- ❑ How should findings listed under “contextual factors” be structured?

Foundations of Contextual Guidance



(Leveson, 2004; adapted from Rasmussen, 1997 and Rasmussen & Svedung, 2000)



(Safar, Roth, & Multer, 2015)

**Note: "PASS" stands for "passing a stop signal" and is synonymous with "Stop Signal Overrun" or SSO.*

Guidance for Contextual Factors

Five categories of contextual factors to consider:

- ❑ Physical system and technology factors
- ❑ Individual and team factors
- ❑ Organizational factors
- ❑ Regulatory factors
- ❑ External / Environmental factors; “Other”

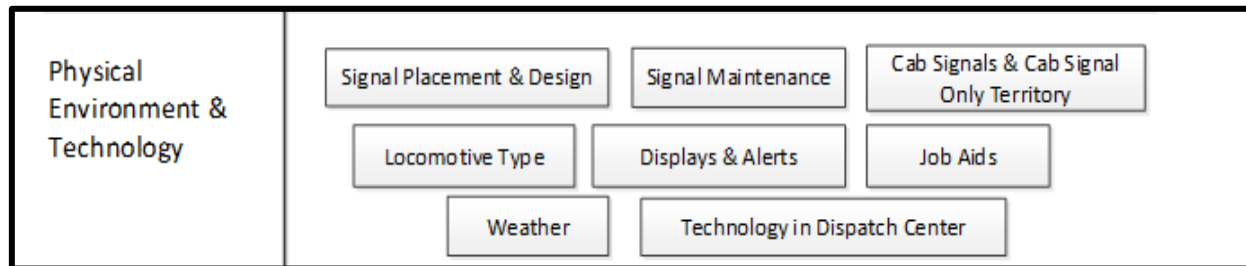
NOTE: This guidance DOES NOT replace the need to create a safety control structure and examine the control and feedback loops specific to YOUR system and controlled process!

This is NOT a checklist; it's a recommendation to consider factors at all levels of your system!

Guidance for Contextual Factors

Physical System and Technology Factors

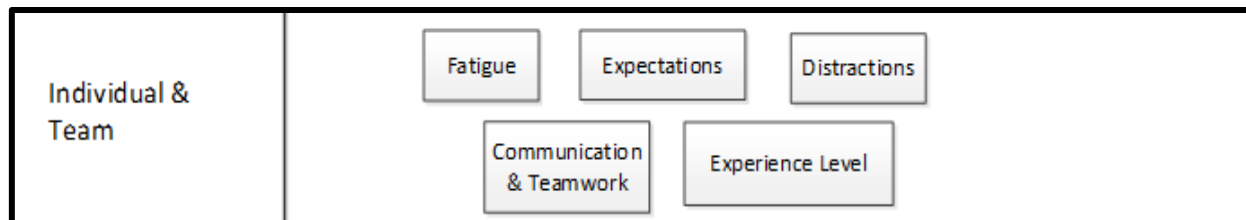
- ❑ Operating environment design
- ❑ Interface design (e.g. displays and alerts)
- ❑ Maintenance/operational status of physical systems
- ❑ Availability or non-availability of job aids
- ❑ Other physical factors (e.g. weather)



Guidance for Contextual Factors

Individual and Team Factors

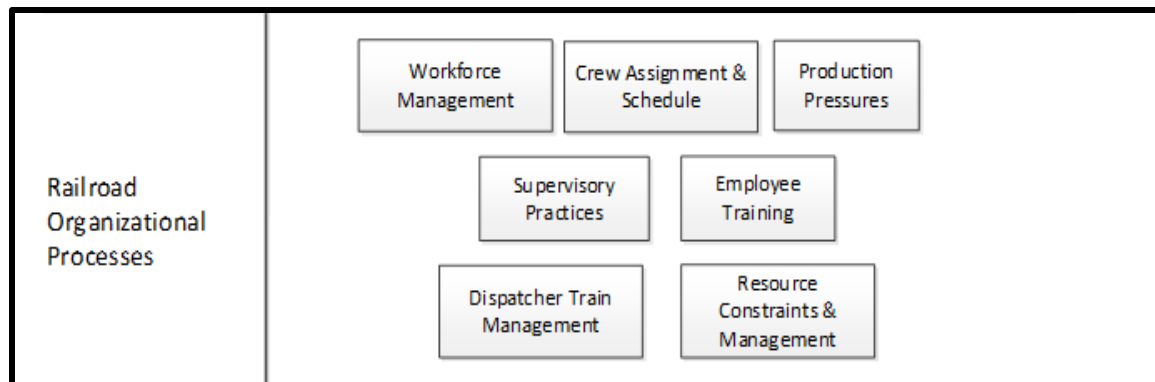
- ❑ Communication and teamwork; coordination
- ❑ Distractions / competing demands for attention
- ❑ Experience level; qualification and training
- ❑ Fatigue; work schedule
- ❑ Medical fitness for duty
- ❑ Expectations; similar situations encountered



Guidance for Contextual Factors

Organizational Processes

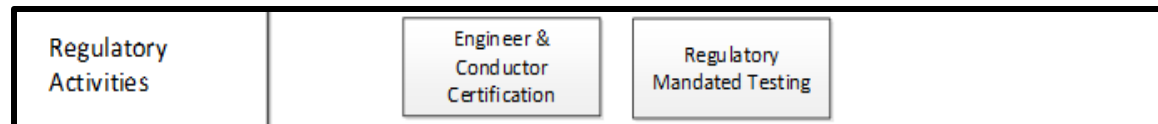
- ❑ Supervisory priorities / safety culture
- ❑ Resource constraints & production pressures
- ❑ Policies and procedures (work schedules, training, discipline, etc.)
- ❑ Degree of feedback from employees



Guidance for Contextual Factors

Regulatory Activities

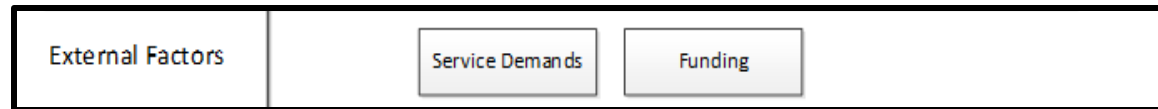
- ❑ Degree of support to/control over organizations
- ❑ Feedback (data) collected from organizations
- ❑ Regulations regarding employees
- ❑ Regulations regarding physical systems and technologies



Guidance for Contextual Factors

External Factors

- ❑ High-level societal, governmental, etc. influences
- ❑ Economic context, funding sources
- ❑ Demands for service driving production pressures
- ❑ Political climate's effects on funding, regulation, etc.



REMINDER: These lists are not comprehensive, they are simply a set of examples!

Complete CAST Controller Guidance

1. Safety Roles & Responsibilities




2. Safety Constraints Violated or Unsafe Control Actions (UCAs)



3. Process Model (Mental Model) Flaws


Explain why Unsafe Control Actions appeared appropriate to the controller.

- A. Mental model of process state
 - B. Mental model of process behavior
 - C. Mental model of environment
- 

4. Contextual Factors

Systemic factors that influence controllers' mental models and decisions.

- A. Physical system and technology factors
- B. Individual and team factors
- C. Organizational processes
- D. Regulatory activities
- E. External factors

A photograph of a railroad crossing. In the foreground, several sets of parallel steel tracks run on a bed of gravel, receding into the distance. Above the tracks, a metal signal gantry structure spans across them. On this gantry, there are three pairs of red signal lights, each pair consisting of a top and bottom light. A small white sign with the text "E NAPERVILLE" is mounted on the gantry. To the left of the tracks, there is a tall metal ladder-like structure and a grey electrical control box. The background is filled with lush green trees under a clear sky.

Objectives & Background
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Head-On Collision of Two Union Pacific Railroad Freight Trains

Goodwell, Oklahoma
June 24, 2012, 10:02 a.m



Photo source: the Guymon Daily Herald courtesy of Marit Edwards

- ❑ 3 fatalities
 - Eastbound train's engineer & conductor
 - Westbound engineer
- ❑ 1 survivor
 - Westbound conductor
- ❑ 5 locomotives and 32 cars derailed
- ❑ \$14.8 million in estimated damage

(NTSB, 2013)

Accidents and Hazards

ACCIDENT

- ❑ A train collides with another train on the same stretch of track

HAZARDS

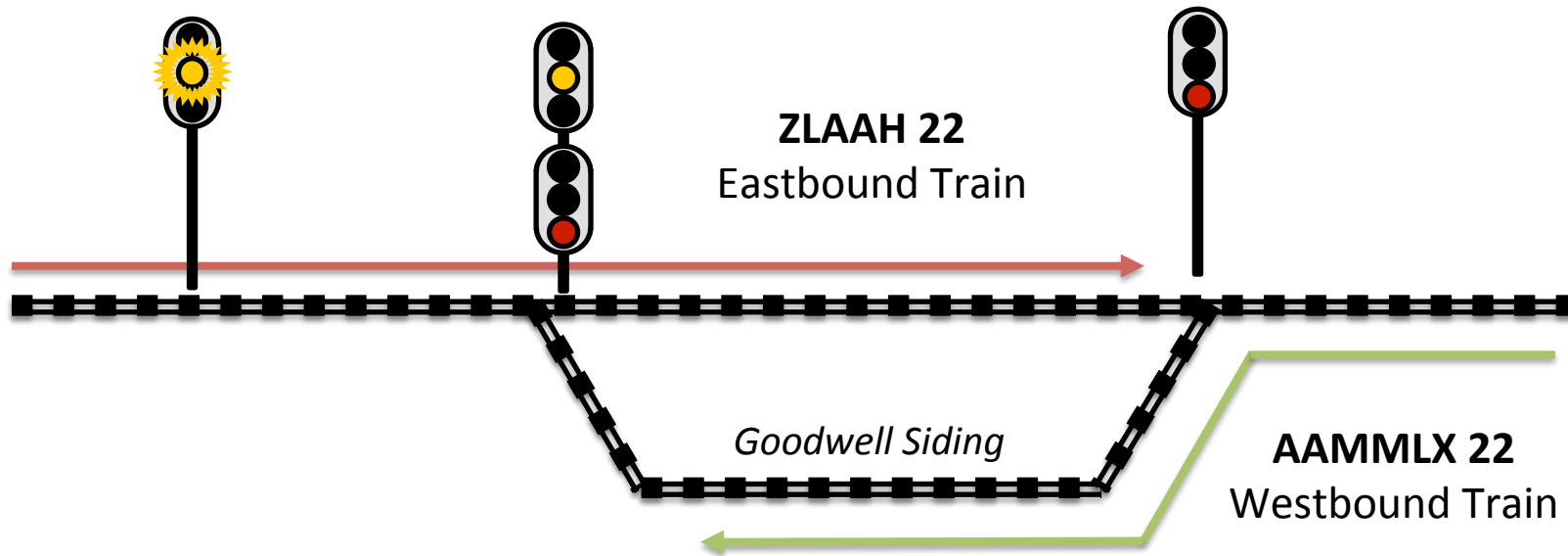
- ❑ A train enters an area of track it was not cleared to enter
- ❑ A train enters an area of track already occupied by another train

System Safety Constraints

- ❑ Dispatchers must use stop and approach signals to alert train crews to areas they do not have clearance to enter
- ❑ Train crews must slow down at approach signals and stop at stop signals
- ❑ Train crews must have adequate visual acuity and color vision to recognize signal indications
- ❑ Railroads must ensure that crews are adequately qualified and medically fit for duty

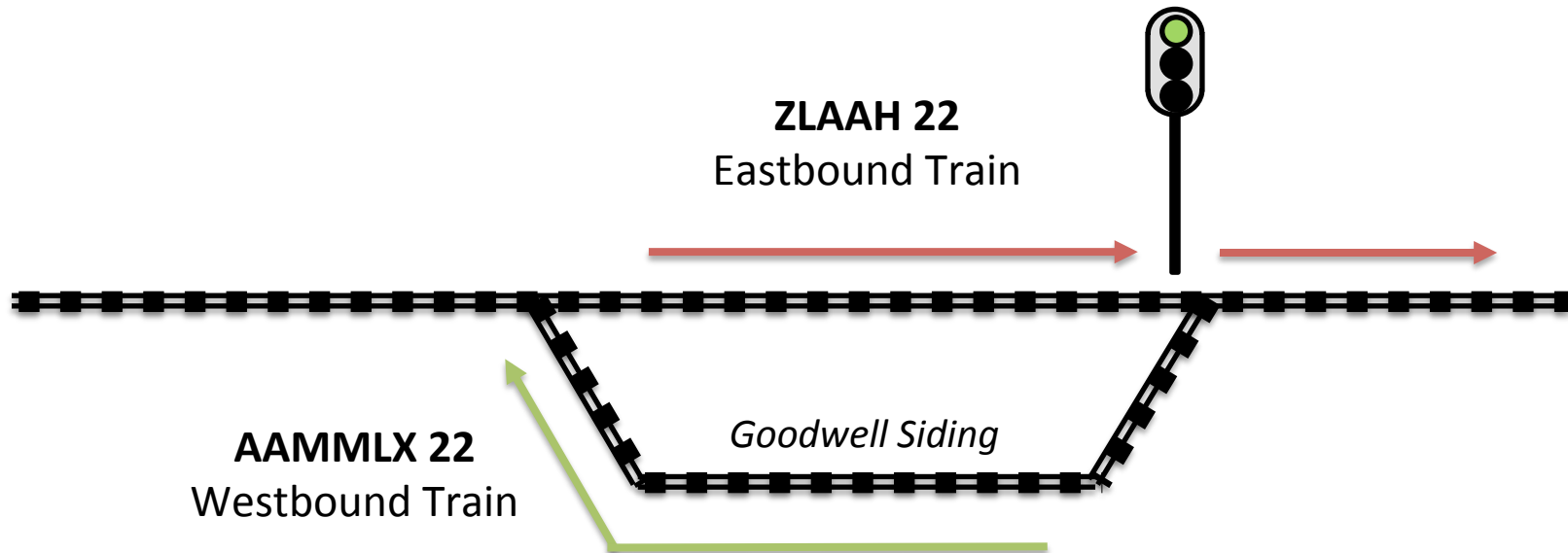
Event Overview: Planned Route

The eastbound train was supposed to wait at the stop signal for the westbound train to enter the siding.



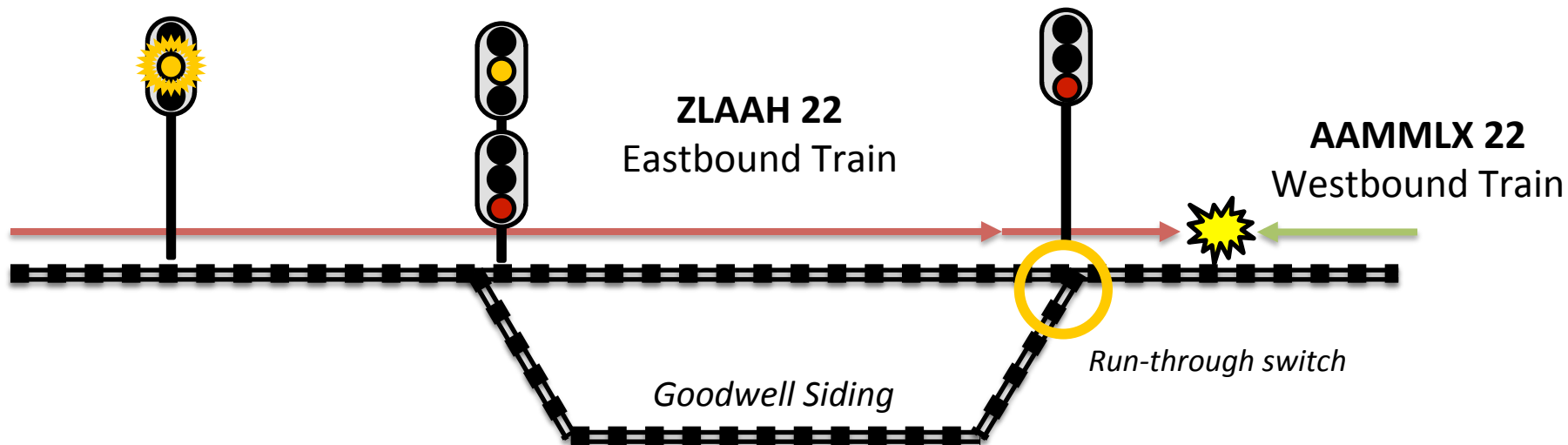
Event Overview: Planned Route

The eastbound train could then proceed forward safely, followed by the westbound train.

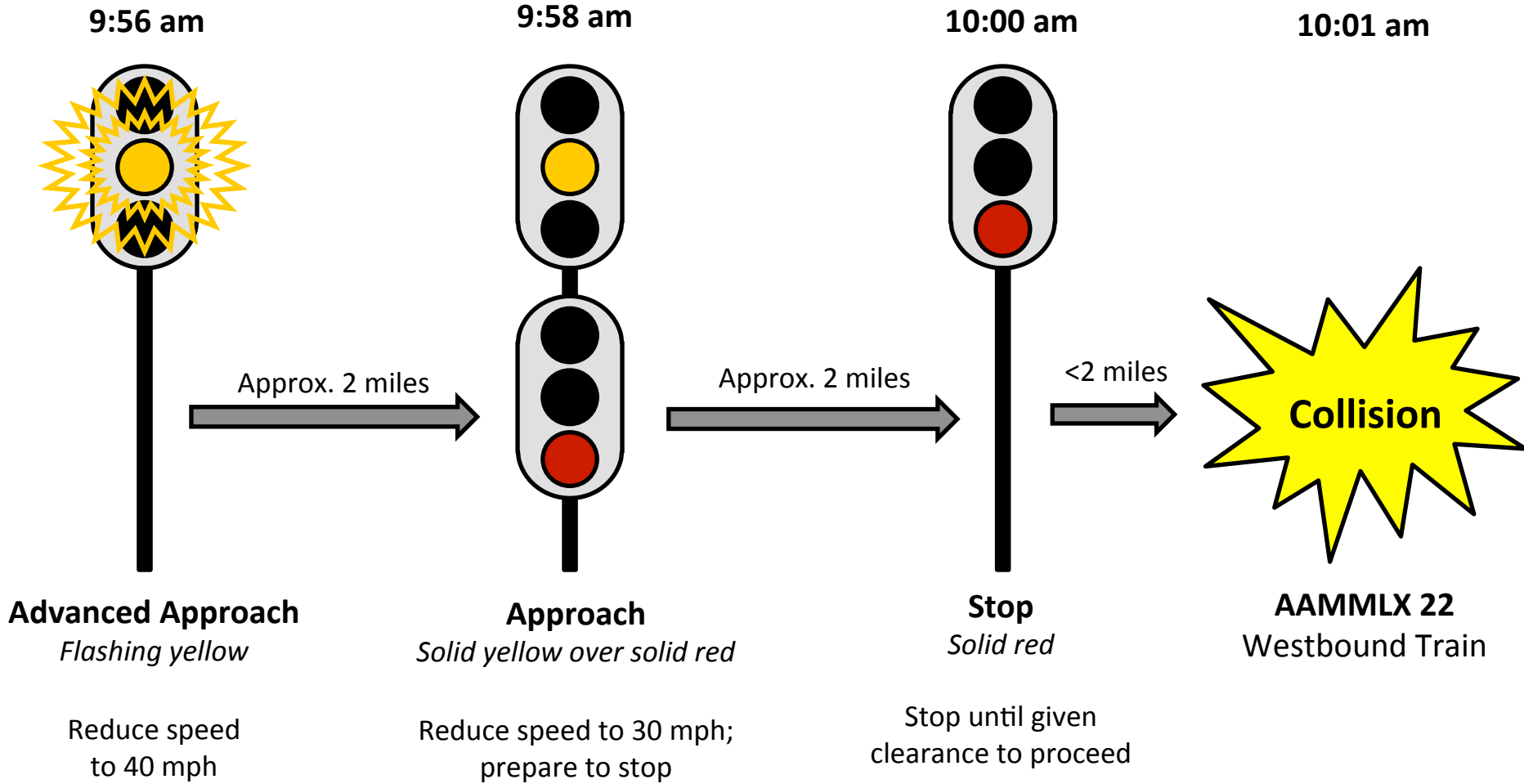


Event Overview: Actual Route

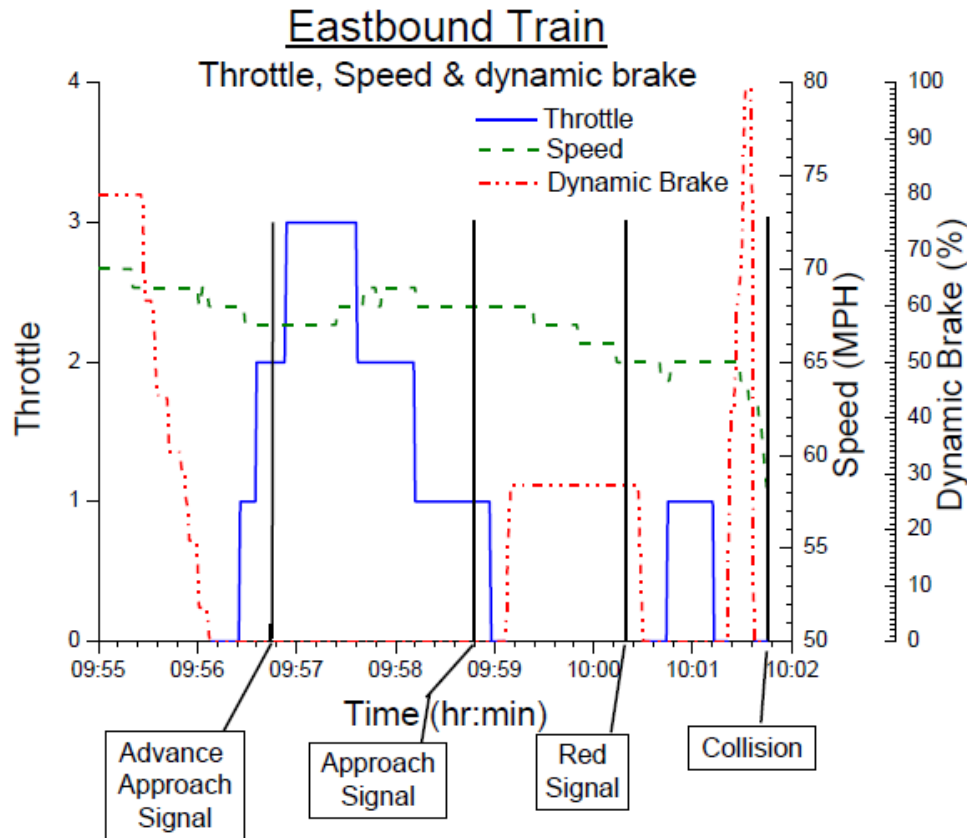
Instead, the eastbound train passed the stop signal and collided with the westbound train before it reached the siding.



Event Timeline: Eastbound ZLAAH 22



Event Timeline: Eastbound ZLAAH 22



“...the engineer appeared to make **throttle** and **dynamic brake** adjustments that maintained **train speed close to the 70 mph limit**, as would be expected for a train operating on a clear signal”

(NTSB, 2013)

Physical System Analysis



(NTSB, 2013)

Safety Controls and Equipment

- ❑ Stop signals indicate where trains must not go
- ❑ “Approach” signals warn of upcoming stop or speed restrictions
- ❑ Sidings allow trains to pass safely on single track

Safety Constraints Violated

- ❑ Two trains moving opposite directions were allowed on a single track

Physical System Analysis



(NTSB, 2013)

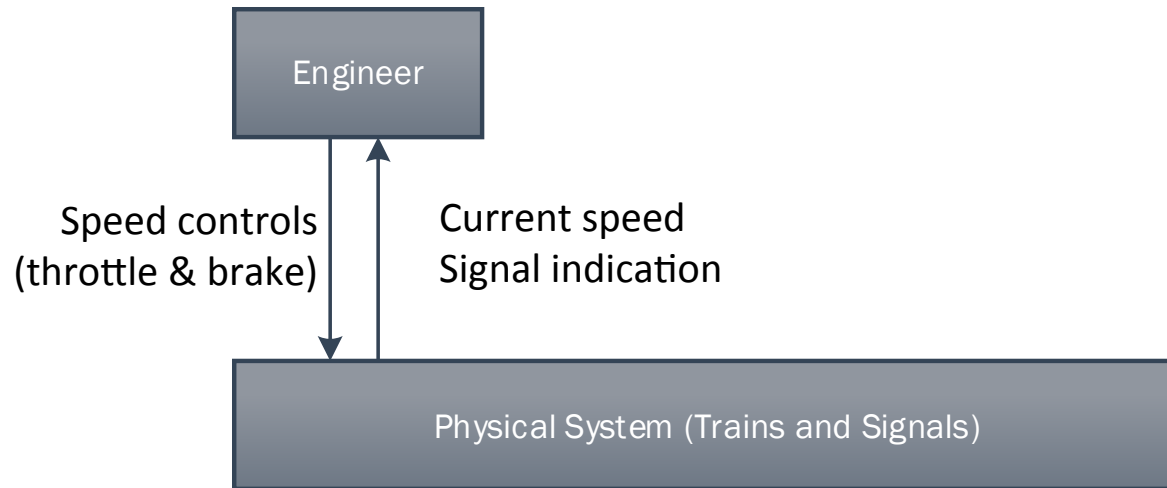
Failures and Unsafe Interactions

- ❑ Signals functioned as intended, but the eastbound train did not obey them
- ❑ No Positive Train Control (PTC) present

Contextual Factors and Additional Questions

- ❑ Individual: If signals were properly functioning, why did the engineer pass a stop signal?
- ❑ Organizational: Why wasn't positive train control installed?

Controller Analysis: Engineer



Controller Analysis: Engineer

Roles and Responsibilities

- ❑ Control train speed in accordance with posted signals; call out signal indication to conductor
- ❑ Be medically fit to operate a locomotive

Unsafe Control Actions

- ❑ Did not slow down as required by approach signals or stop at the stop signal
- ❑ Operated while knowing he had inconsistent color vision and diminished visual acuity

Controller Analysis: Engineer

Mental Model Flaws

Model of Process State:

- ❑ Incorrectly believed signals were “clear” (green)

Model of Process Behavior:

- ❑ *N/A – understood meaning of signals & required actions*

Model of Environment & Controllers:

- ❑ May have incorrectly believed conductor would intervene
- ❑ Likely unaware of the presence of another train

Controller Analysis: Engineer

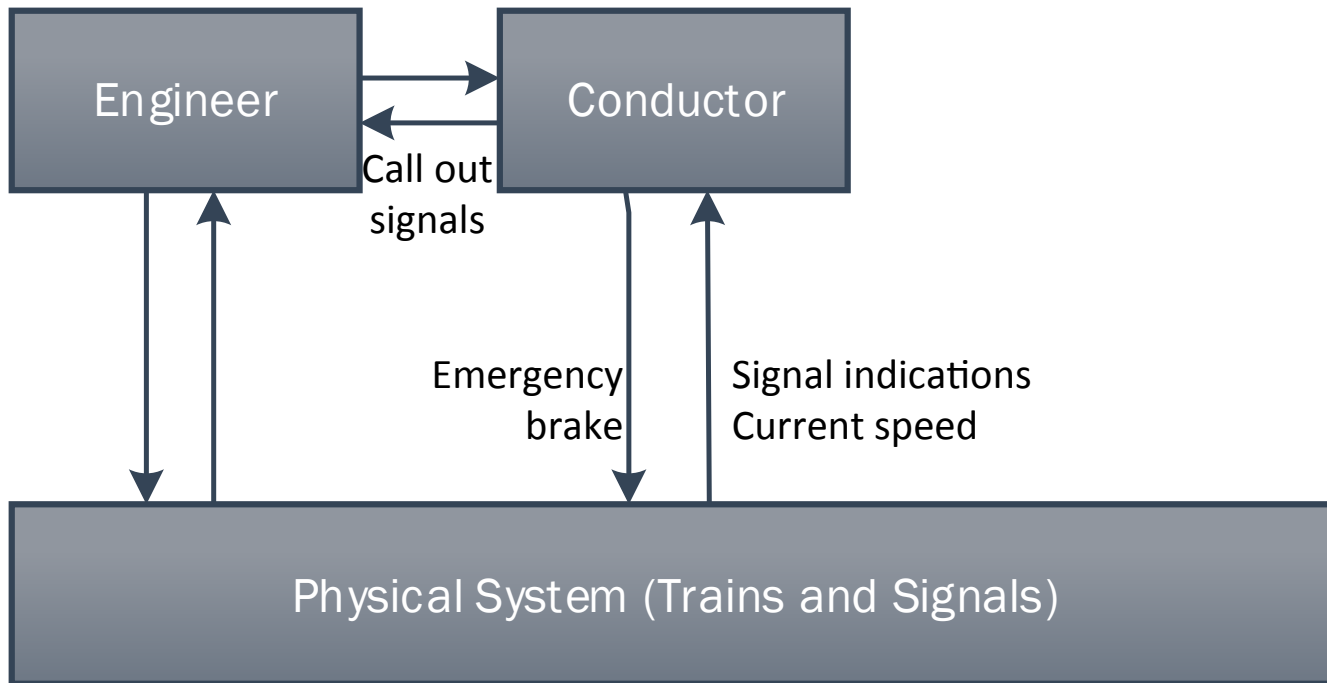
Individual Contextual Factors:

- ❑ Perceptual limitations: engineer had severe visual impairments from multiple conditions; had failed a color vision test in 2009
- ❑ Coordination: should have been coordinating with conductor to call out signals and ensure proper speed; what was conductor doing?
- ❑ Expectations: signals may be typically clear, high-visibility
- ❑ Fatigue: fatigue possible based on irregular work schedule

Organizational Contextual Factors:

- ❑ What organizational factors allowed (or incentivized) operating despite severe visual severe limitations?

Controller Analysis: Conductor



Controller Analysis: Conductor

Roles and Responsibilities

- ❑ Call out signal indications; ensure engineer obeys signals; use emergency brake if necessary

Unsafe Control Actions

- ❑ Apparently did not call out the approach and stop signals; did not warn engineer
- ❑ Did not pull the emergency brake

Controller Analysis: Conductor

Process Model Flaws

Model of Process State:

- ❑ Was likely unaware that signals were in a restrictive state

Model of Process Behavior:

- ❑ *N/A – would have understood meaning of signals*

Model of Environment & Controllers:

- ❑ Was likely unaware that the engineer was not responding to signals; likely believed engineer could read the signals

Controller Analysis: Conductor

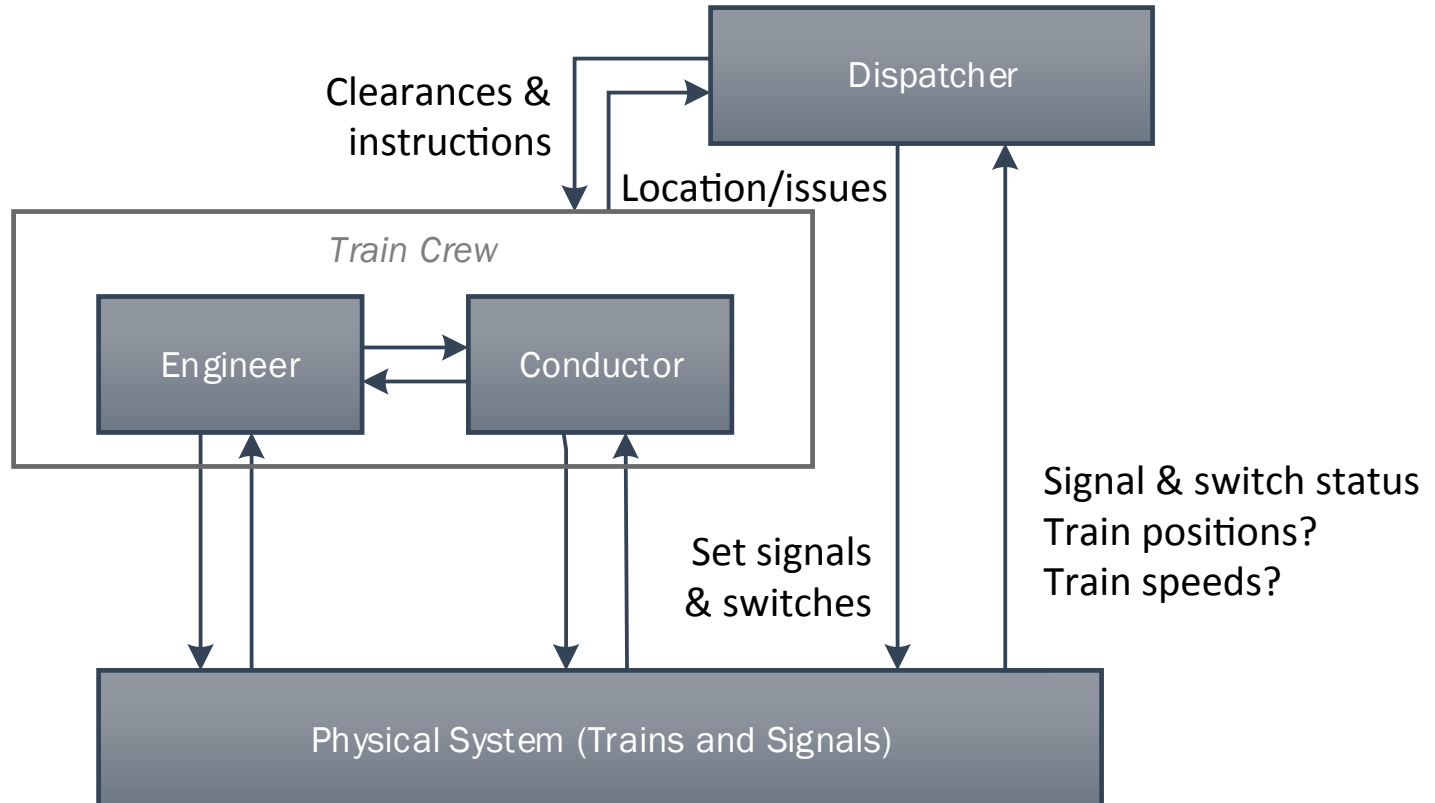
Individual Contextual Factors:

- ❑ Distraction / inattention: conductor may have been asleep or absent
- ❑ Expectations: signals may be typically clear, high-visibility conditions, may have believed engineer was capable of recognizing signals
- ❑ Fatigue: fatigue possible based on irregular work schedule
- ❑ Coordination: engineer may have allowed conductor to rest

Organizational Contextual Factors:

- ❑ What organizational factors contributed to lack of required coordination between the engineer and conductor?

Controller Analysis: Dispatcher



Controller Analysis: Dispatcher

Roles and Responsibilities

- ❑ Set signals and switches for safe routing of trains
- ❑ Communicate route information to train crews

Unsafe Control Actions

- ❑ Apparently did not warn eastbound train crew about the upcoming stop signal & other train

Controller Analysis: Dispatcher

Process Model Flaws

Model of Process State:

- ❑ Did not realize eastbound train had passed the signals

Model of Process Behavior:

- ❑ May have believed that if crews passed a signal, he would be alerted and have time to intervene

Model of Environment & Controllers:

- ❑ Assumed crew would obey signals even if not given warning

Controller Analysis: Dispatcher

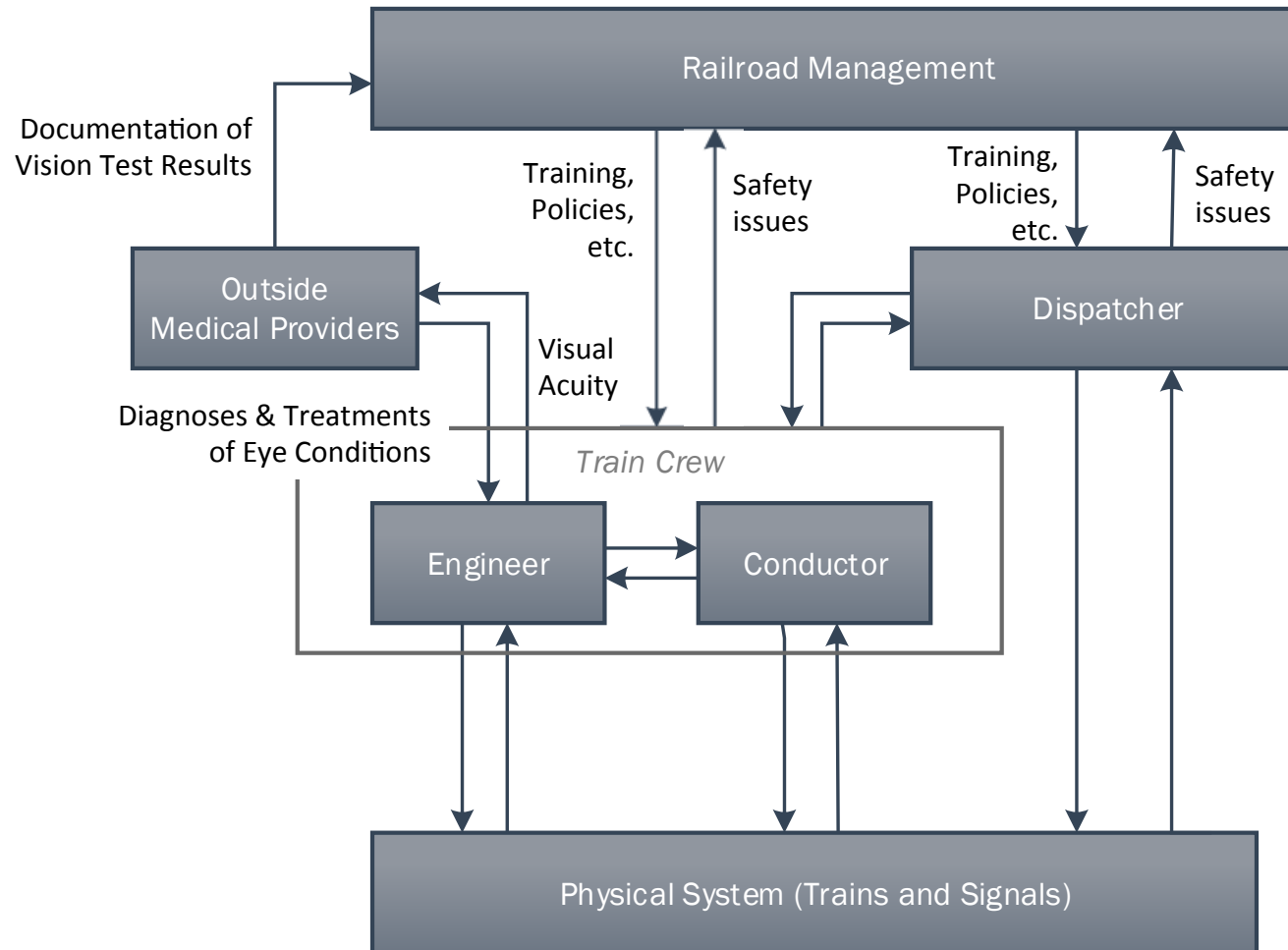
Physical System Contextual Factors:

- ❑ Dispatcher was not notified that the train was over the speed limit
- ❑ Dispatcher was only notified once the switch at the end of the siding was pushed out of alignment by the eastbound train

Individual Contextual Factors:

- ❑ Expectations: did not expect crews to pass a stop signal (very rare)
- ❑ Coordination: dispatcher was responsible for 10-12 crews
- ❑ Timing: accident occurred approx. 5 mins after first missed signal, and less than 2 minutes after the dispatcher received an alert

Controller Analysis: UP Management



Controller Analysis: UP Management

Roles and Responsibilities

- ❑ Ensure that employees are medically fit for duty and adequately trained on job tasks, including coordination
- ❑ Ensure that physical system complies with regulations

Unsafe Control Actions

- ❑ Did not have PTC installed on the route
- ❑ Did not provide training on crew resource management
- ❑ Did not require documentation of engineer's visual acuity results; did not require follow-up testing
- ❑ Used a color vision test of unknown validity / reliability

Controller Analysis: UP Management

Mental Model Flaws

- ❑ May have incorrectly believed engineer's vision was okay
- ❑ May have believed that engineer's vision would not be a problem with the conductor assisting by calling out signals
- ❑ May have believed resources were not available to implement safety measures, or that safety measures were not as urgent as other priorities (CRM, PTC)

Controller Analysis: UP Management

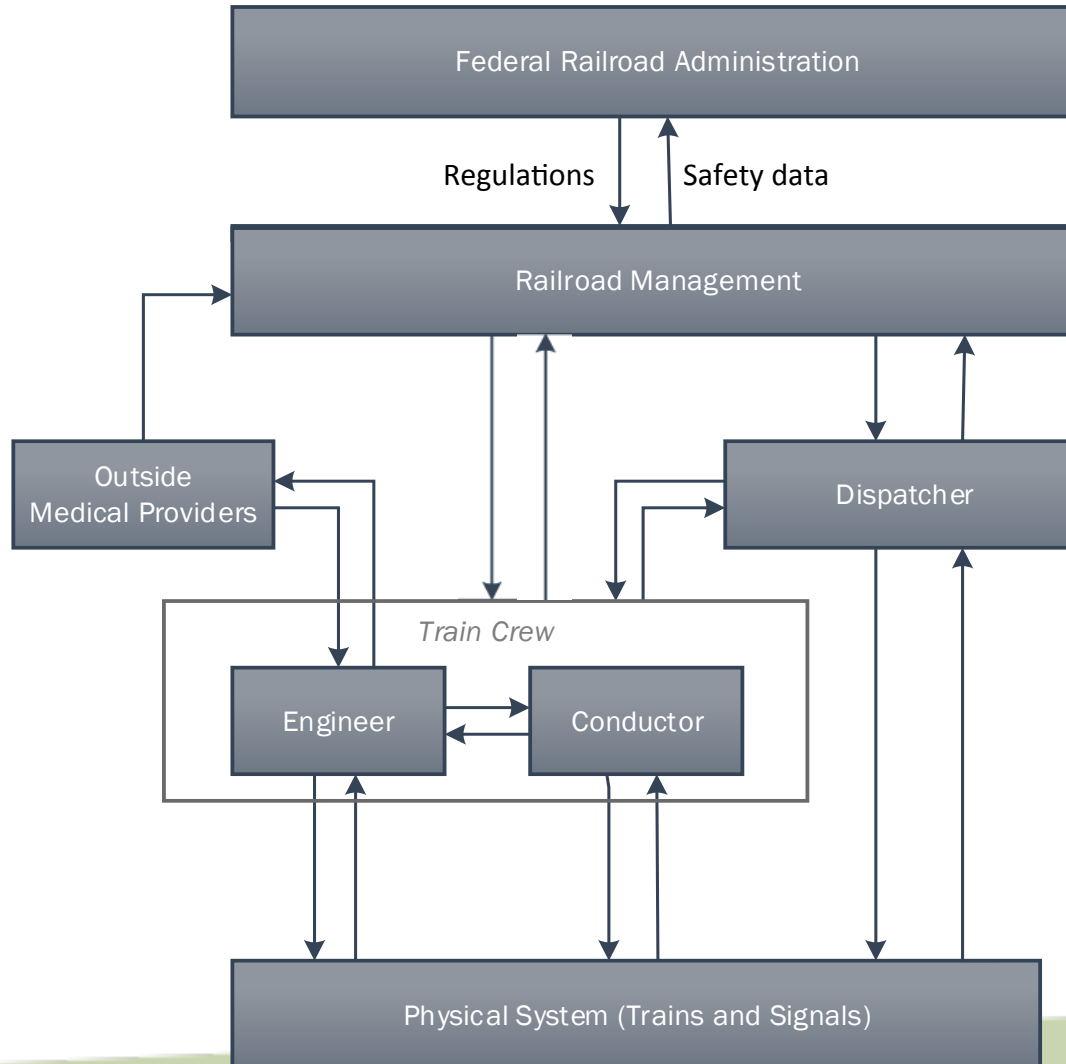
Organizational Contextual Factors:

- ❑ Resource constraints: PTC / CRM require large amount of resources
- ❑ Staffing constraints: may have needed engineers badly, decided to keep the engineer despite visual limitations
- ❑ Policies: did not uniformly apply policy for verifying visual acuity was to obtain written documentation
- ❑ Scheduling practices: irregular schedules are common in rail industry; may contribute to fatigue despite hours of service limitations

Regulatory Contextual Factors:

- ❑ Was UP in violation of regulations, or were regulations inadequate?

Controller Analysis: FRA



Controller Analysis: FRA

Roles and Responsibilities

- ❑ Regulate railroads to ensure safety standards

Unsafe Control Actions

- ❑ Allowed retaking vision tests without validating railroad's testing methods
- ❑ Did not mandate PTC installation sooner
- ❑ Did not mandate CRM trainings

Controller Analysis: FRA

Process Model Flaws


- ❑ Believed timeline for PTC implementation was appropriate
- ❑ Believed railroads had adequate resources for CRM
- ❑ Believed railroads would use a valid vision testing method

Regulatory Contextual Factors:

- ❑ FRA already required implementation of PTC by 2015
- ❑ FRA conducted research into CRM, provided railroads with funding for pilot programs

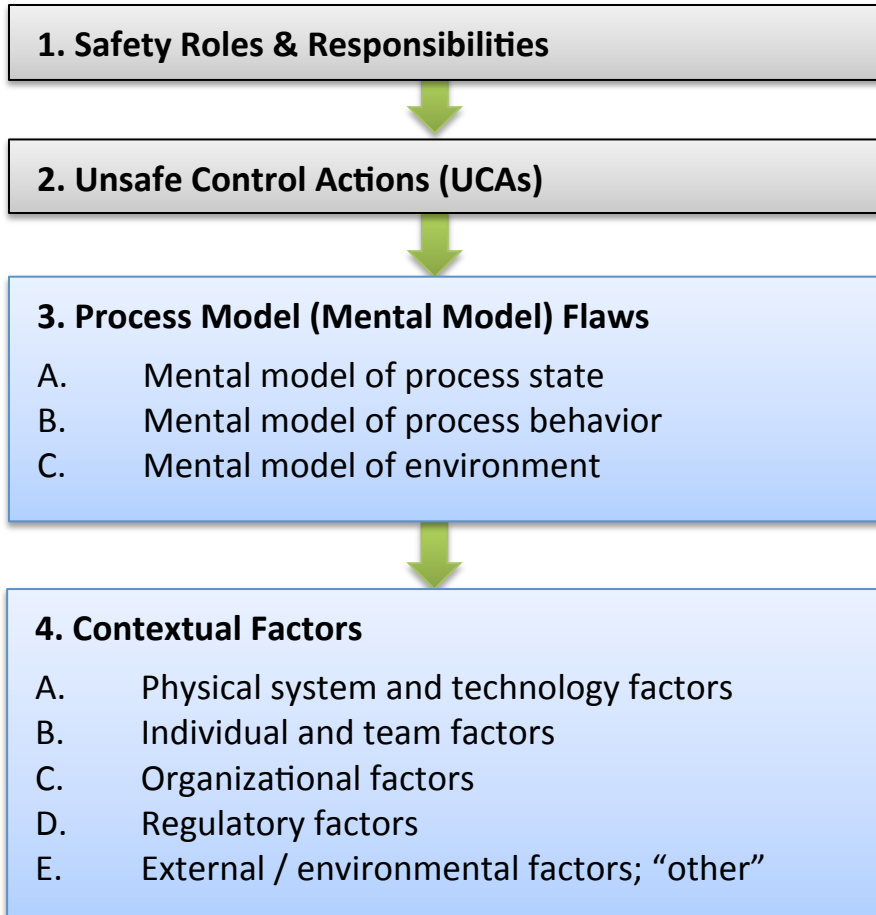
External Factors

- ❑ Desire to maintain positive relationships with railroads & work within their resource constraints (e.g. PTC regulation timing)

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Enhanced CAST Controller Guidance



- ❑ Provides additional guidance on what types of content to include
- ❑ Useful for new practitioners of CAST
- ❑ Revealed interesting results in our freight case study

References

- ❑ France, M., “Engineering for Humans: A New Extension to STPA,” Master’s Thesis, Massachusetts Institute of Technology, 2017.
- ❑ France, M., “Engineering for Humans: Human-Automation Interaction in STPA,” presented at the 6th Annual MIT STAMP Workshop, 2017.
- ❑ Leveson, N. G. “A New Accident Model for Engineering Safer Systems.” Safety Science, vol. 42, no. 4, pp. 237-270, 2004.
- ❑ Leveson, N. G., “Engineering a Safer World: Systems Thinking Applied to Safety.” The MIT Press, 2012.
- ❑ National Transportation Safety Board, “Head on Collision of Two Union Pacific Railroad Freight Trains Near Goodwell, Oklahoma, June 24, 2012.” NTSB/RAR-13/02. Washington, DC: NTSB, 2013.
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- ❑ Safar. H., Multer, J., & Roth, E. “An Investigation of Passing Stop Signals at a Passenger Railroad” Washington, DC: Federal Railroad Administration, 2015.
- ❑ Safar. H., Multer, J., & Roth, E. “Why do passenger trains pass stop signals? A systems view” Washington, DC: Federal Railroad Administration, 2017.
- ❑ Thomas, J. and M. France. “Engineering for Humans: STPA Analysis of an Automated Parking System,” presented at the 5th annual MIT STAMP Workshop, 2016.

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Thank you for your attention!

Contact:

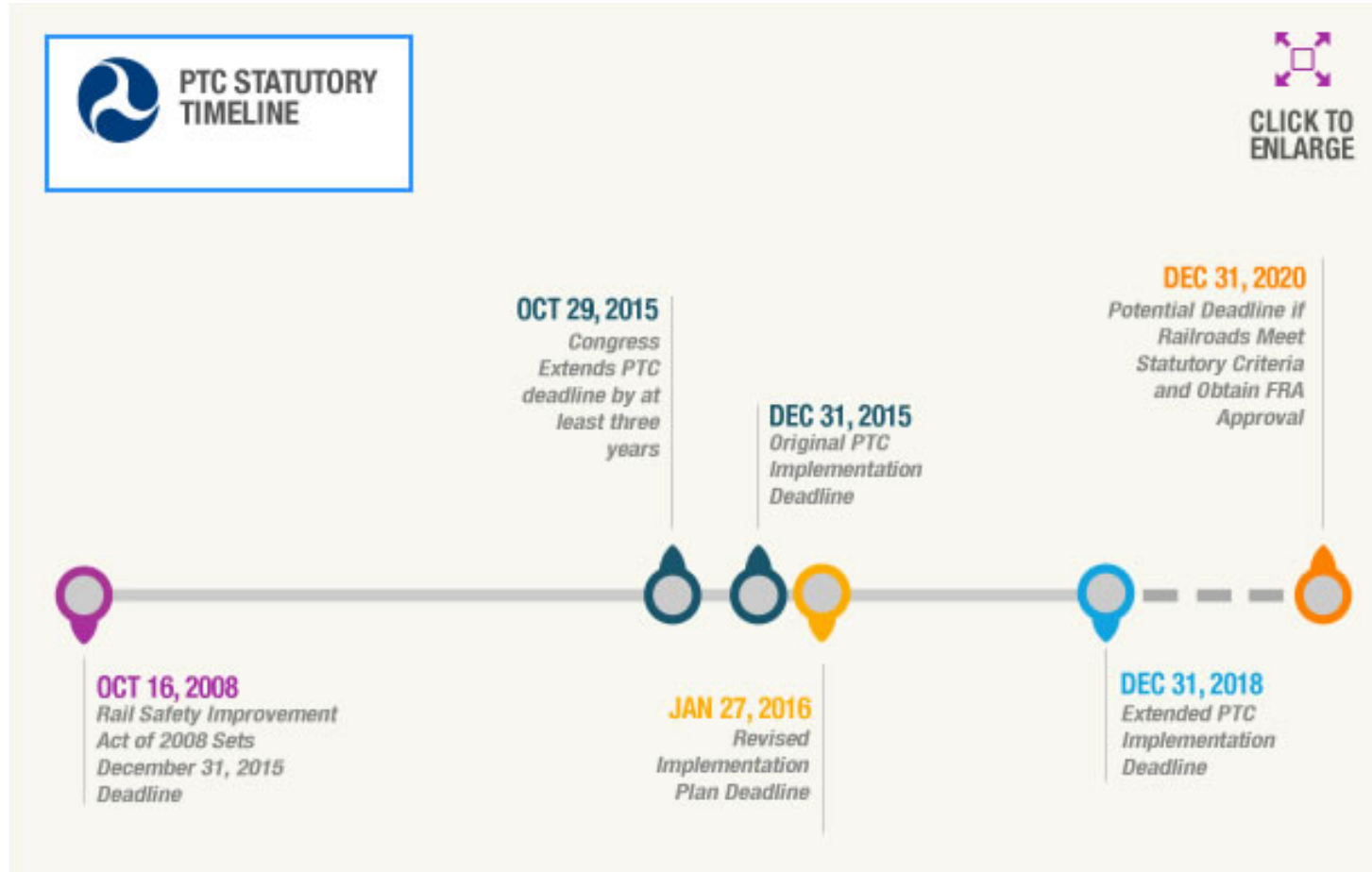
Megan France, US DOT Volpe Center

megan.france@dot.gov

A photograph of a railroad crossing with three sets of red PTC (Positive Train Control) signals mounted on a metal structure. The structure has a sign that reads "E NAPERVILLE". The tracks lead into the distance, flanked by trees and utility poles. A red semi-transparent box is overlaid on the center of the image, containing the text "Backup Slides: PTC Implementation".

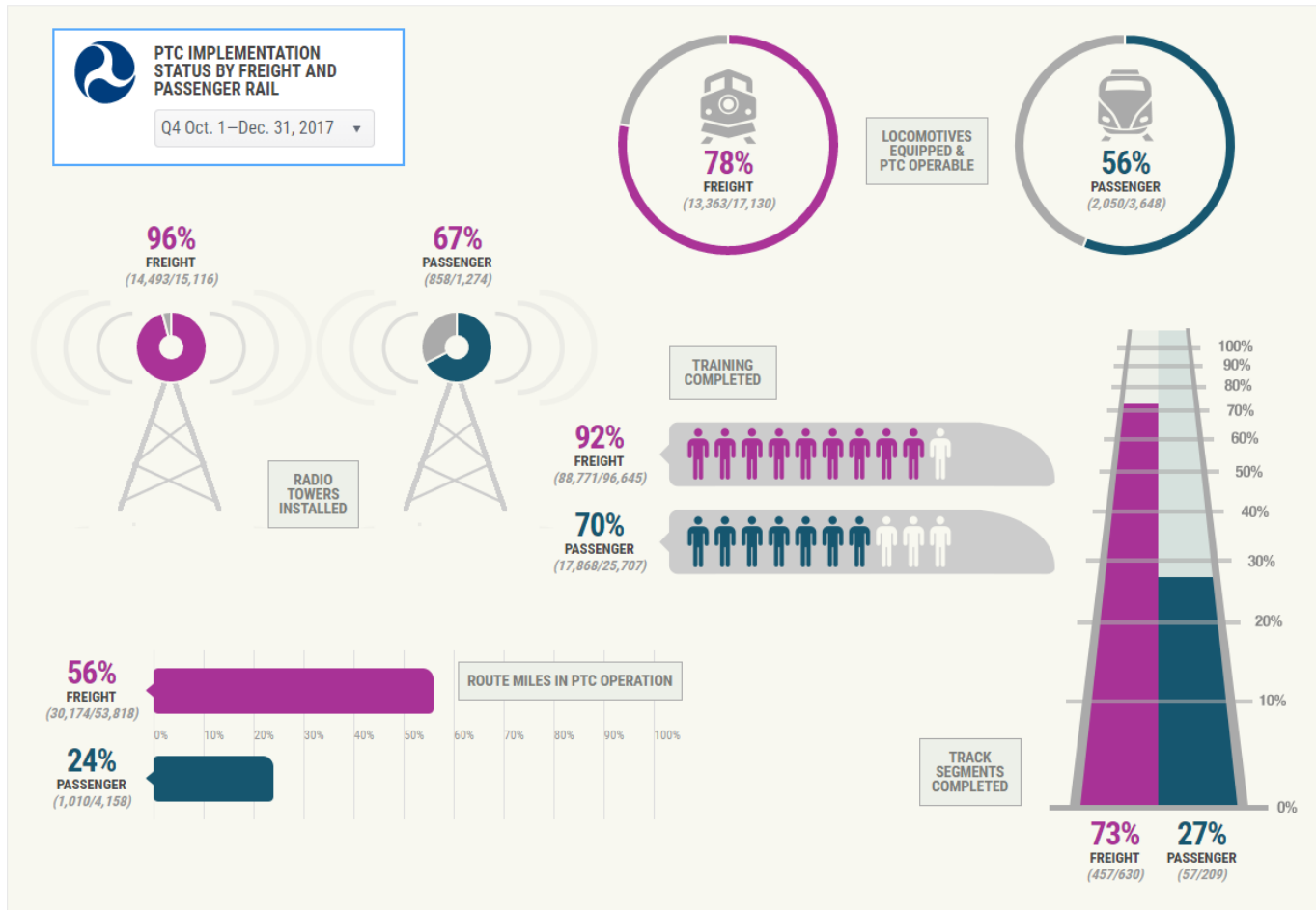
Backup Slides: PTC Implementation

Positive Train Control Timeline



Source: <https://www.fra.dot.gov/ptc>

PTC Implementation in Freight RRs



Source: <https://www.fra.dot.gov/ptc>

PTC Implementation at UP

As of December 31, 2017



Source: <https://www.fra.dot.gov/ptc>

Ongoing/Future Work on SSOs

- ❑ Current study focuses on freight environment
 - CAST analyses are a preliminary step
 - Follow-up with interviews, focus groups, etc. and briefing to railroad management
- ❑ Other ongoing work
 - Improving SSO data collection using a common form template
 - Communicating findings to railroads in a “Good Practice Guide”