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 me today are my colleagues on the Board, Member Christopher Hart, 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 April 3, 2016 collision of an Amtrak train with maintenance-of-way equipment near Chester, Pennsylvania.

The train struck a backhoe at 99 mph and derailed. The backhoe operator and another roadway worker died, and 39 occupants of the train were injured.

On behalf of my colleagues on the Board and the entire NTSB staff, I would like to offer our sincerest condolences to the families and friends of those who died in this crash. And we hope that those who were injured are on the way to the fullest possible recovery. As always, the NTSB's purpose in this investigation is to learn from what happened, to prevent future accidents.

And, I’m confident that the findings of this investigation, and the safety recommendations that stem from it, if implemented, will indeed improve safety.

There are many aspects of this tragic event, but I want to focus on what I consider to be the underlying issues – the way that Amtrak fundamentally attempted to manage safety and compliance. In this accident, investigators found a railroad that was adamant about employees following safety rules. And there’s no doubt that following rules is indispensable to running a safe railroad.

But in interviews, executives and managers emphasized rule-following as practically the only method of assuring safety on the railroad. Amtrak provided a list of “Cardinal Rules.” Breaking any of these rules is likely to result in being fired.

Nevertheless, the investigation revealed more than two dozen unsafe conditions, and not all were rule-breaking by front-line employees. Clumsy Amtrak procedures seemed to encourage work-arounds by workers to “get the job done.” Critical safety equipment, known as Supplemental Shunting Devices, which could have prevented this tragic situation, were not issued to this maintenance of way crew.

And 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 rules on the other.

A culture of fear and a strong safety culture cannot coexist. And, indeed, in this accident, investigators found a labor-management relationship so adversarial that safety programs became contentious issues at the bargaining table, with the unions ultimately refusing to participate in two out of three programs.

By focusing solely on compliance and punishment, Amtrak missed opportunities to improve safety through established top-down safety management principles. And, they shut down the reporting of valuable safety information from their employees.

In addition to other aspects of this accident, today we will take a deep dive into Amtrak's safety culture – how its weaknesses set the stage for this accident, and how it can be improved.

We'll also note positive post-accident actions, both by Amtrak and by the FRA, but we'll point out ways Amtrak and the FRA can further enhance safety.

It’s hard to correct systemic problems, but the alternative is unacceptable. And correcting these problems will yield safety benefits across the board.

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

###