FIRST TRANSIT RAIL

ADVISORY COMMITTEE for SAFETY

(TRACS) MEETING

U.S. DEPARTMENT OF TRANSPORTATION

THURSDAY, SEPTEMBER 9, 2010

9:00 -- 5:00 p.m.

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THURSDAY, SEPTEMBER 9, 2010

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Deputy Secretary of Transportation

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MR. FLANIGON: Let's go around the table briefly with the committee, starting with Mr. Pearson to just do self-introductions. If you could just state your name and your position and the organization that you are with.

MR. PEARSON: I'm Alvin Pearson. I'm the assistant general of operations for the Memphis Area Transit Authority in Memphis, Tennessee.

MR. DOUGHERTY: Good morning, Jim Dougherty, chief safety officer, Washington Metropolitan Transit Authority, WMATA, Metro here in Washington, D.C.

MS. McCOMBE: Good morning. My name is Pamela McCombe, and I'm the director of safety for the Greater Cleveland Regional Transit Authority.

MR. CHENG: Good morning. My name is Eric Cheng from Utah Department of Transportation, (inaudible).

MR. CLARK: Good morning. I'm Richard
Clark, the director of Consumer Protection and Safety at the California Public Utilities Commission.

MR. KRISAK: Rich Krisak, I'm with MARTA. I'm the HM of rail operations and development.

MS. GREGORY: Georgetta Gregory. I'm with MARTA also as the HM of safety and quality assurance.

MR. HARTBERG: Henry Hartberg, senior manager operations safety for Dallas Area Rapid Transit.

MR. HARDY: Len Hardy with the San Francisco Bay Area Rapid Transit District.

MS. BRIDGES: Bernadette Bridges, director of safety for the Maryland Transit Administration.

MR. PRENDERGAST: Tom Prendergast, president of the New York Transit, sitting in for Linda Kleinbaum from the Metropolitan Transportation Authority.
MR. INCLIMA: Good morning. Rick Inclima director of safety, Brotherhood of Maintenance of Way Employes division of the Teamsters Rail Conference.

MR. SOUTHWORTH: Jim Southworth, chief of the railroad division, National Transportation Safety Board.

MS. KOVALAN: Amy Kovalan, the chief safety and security officer at the Chicago Transit Authority.

MS. JETER: Jackie Jeter, president of the ATU Local 689 here in Washington D.C.

MR. WATT: Ed Watt, director of health and safety, Transport Workers Union.

MR. BATES: Good morning, William Bates, United Transportation Union, District of Columbia, legislative director.

MR. GENOVA: Good morning, David Genova. I'm the assistant general manager of safety and security for a regional transportation district in Denver.
MS. DAVIDSON: Good morning. I'm Diane Davidson, Oakridge National Laboratory. I'm the director of the Center for Transportation Analysis.

MR. GRIZARD: Good morning, everyone, Bill Grizard. I'm the director of safety for American Public Transportation Association.

MR. FLANIGON: Thanks very much. We have really assembled an impressive group, and we want to thank you for being here with us today.

Now John Porcari, Deputy Secretary of Transportation would like to make a few opening remarks.

MR. PORCARI: Thank you. First of all, on behalf of Secretary LaHood, who will be here momentarily, and Administrator Peter Rogoff, thanks for doing this. This is really important.

At the Department of Transportation, we say safety is our top priority. That is just not a slogan. One of the first actions that Secretary LaHood took after coming in as Secretary was to
set up an intermodal safety council that included the chief safety officers and the modal administrators from the entire Department, all 10 modes.

That was a way that we could work on a common safety agenda to make sure our research, our data gathering and our regulatory activities were all geared towards some of the most important safety issues that we have. And clearly across the mode, whether you are in a cockpit or you are an operator of a transit vehicle or driving your car, things like distraction and fatigue are crosscutting issues. They are very important. So the safety council was set up to do exactly that.

The first official action that the safety council took, actually, was to endorse this transit safety legislation that is currently pending before the Congress. I think from my perspective, it is a unique historical oversight that the Federal Transit Administration is explicitly prohibited from having the kind of
active safety role that I think would serve the industry and our transit properties as well.

We seek to correct that. You will hear from Secretary LaHood that he feels very passionately about this. And that going forward in a partnership with TRACS right in the center of this effort, we aim to take an already very safe transportation mode and make it as safe as possible.

One of the confidence building measures that we can have to build ridership and to make transit a true transportational term in the future is to make these very visible, very specific, very concrete gains in safety. We can't do that without the kind of input that TRACS will give us.

And, so, going forward after the kick off today, we ask for your active participation in the group, we would -- we are looking for your very specific feedback as part of it. And as you are interacting with the colleagues throughout the industry, we need to make sure that you are
bringing forward the viewpoints of the industry.
What I can guarantee you is that the transit
safety input that you provide will be go directly
to the Administrator, myself and the Secretary as
something we take very seriously, and the goal is
nothing less than to make our transit operations
in the United States the safest in the world.

And one of the interesting sidelights
that we found through this process is that there
is not very good data throughout the world on
transit safety. The data gathering part of it
will be an important part of our activities.

So, with that as an introduction and
with impeccable timing is Secretary LaHood and
Administrator Rogoff are here this morning. And
let me introduce first Administrator Peter Rogoff
to introduce the Secretary. Peter.

(Applause)

MR. ROGOFF: Good morning. I thank
everybody. I'm going to introduce the Secretary,
and the Secretary will make some remarks, and I
will make follow-up remarks.

Let me first thank you all for being here, thank you all for volunteering to provide your expertise and your service to this important advisory committee. We are very pleased this morning to have as an opportunity to kick off the inaugural meeting of TRACS with Secretary Ray LaHood.

I can tell you in the 21 years of dealing with federal transportation policies, we have had a great many secretaries who have said that safety is their number one priority. We now have one that truly lives and breaths it every day in every question that comes before us in any mode, and his presence here is indicative of the leadership that he has brought to this issue, and the importance that he personally attaches to it. And that that importance and that message is fused down to each of the modes and each of the employees working in the modes.

Secretary LaHood has been nothing but
supportive of the overall transit industry, the overall drive of the President to use public transportation as an opportunity to improve the liveability of Americans, to improve the air we breathe, to improve the environment that we leave to our kids, to improve mobility and relieve congestion. And I personally want to thank him for the leadership that he has brought not just to public transportation in general, but also to his public transportation safety challenge that we have taken on so vigorously under his leadership.

So, with that, I will just say thank you once again and ask you to welcome Ray LaHood.

(Applause.)

SECRETARY LaHOOD: Thank you all for coming to Washington and participating in this meeting. I think all of you know that over the last 18 months that we have had this job, we have promoted safety. It is our number one priority. It is not just words that we say. We have conducted ourselves, I think, in a way that has
shown that safety really is our priority.

After the terrible crash in Buffalo, New York, Randy Babbitt, our FAA Administrator, took it upon himself to travel the country and hold 12 safety summits. We have a very strong enforcement, what we call rule pending now at OMB to try and deal with some of the safety concerns that were expressed by the NTSB and others as a result of that crash. After the WMATA crash here in Washington. It sparked our interest in wondering why we had not played more of a role in safety when it came to WMATA and other transit organizations. And for me personally discovered that the law prohibits us from doing that. You know, how insane is that to think that the agency that has some responsibility for transit all over the country has no responsibility for the safety of the people that ride the trains and buses?

So we think what you all are doing is absolutely critical to our mission, our safety mission. And I was more than stunned when I had
the privilege of sitting up on the dais, I guess, or the platform on the day that President Obama was sworn in and saw 2 million people. I had been to other inaugurations, but I never been to one where 2 million people showed up.

But most extraordinary for me is that all of those people were delivered around America's city by America's transit, WMATA. And people who work for WMATA have to be very proud of what they did to deliver all of those people, all over this region, during that 2- or 3-day celebration.

And I think about that and then I think about what you all do in your own opportunities to deliver people. The one thing that people want from their bus system, their light rail system, their streetcar system, their transit system is to make sure when they get on it that they are safe. You know that.

I mean, that is the one thing people take for granted when people board an airplane,
when they get on a bus, when they get in a car.
The one thing that they want is that it will be safe, that the equipment is the right equipment, that it is equipment that is safe, and that people are driving these machines and modes of transportation are well trained.

And, so, everything that we have done for the last 18 months, whether it is trains, planes or automobiles, has revolved around safety. In a few weeks we are going to have a second distracted driving summit. And we are on a rampage about the idea that distracted driving is a real epidemic in America.

The reason it is an epidemic is because about every American, just about 100 percent have cell phones. And anybody who has had a cell phone and has a driver's license, has used their cell phone while driving, you cannot drive safely and use a cell phone, you cannot drive safely and text, you cannot drive a train safely while you are texting or an airplane.
You saw what happened to those two pilots who overshot Minneapolis because supposedly they were on the computer. You have seen what happened in other areas of the country where train drivers think they can drive a train safely or a bus safely and text and drive, you can't do it. So, we are going to continue that.

The one thing that is very important to us is that Congress passes safety legislation. Peter has done a great job on this. Peter Rogoff. And I think those of you who now have worked with Peter know he has really done a great job as our Administrator. He really has. He is very serious about this job. Right after the WMATA crash, he and I talked about the idea that we didn't have the responsibility for safety. And so Peter and his staff, along with some staff that he was acquainted with on Capitol Hill, put together, we think, a very good safety bill, safety transit bill.

And because of the good relationships
that Peter has on the Senate side, Senator Dodd voted out of his committee on a voice vote our transit safety bill. So now today we are sending a letter to the leadership of the Senate, Senator Reid and Senator McConnell, asking to consider that bill on the Senate floor. We think it is important.

If they do that before they break for the election, it will send a very clear message that we are serious about this, and that Congress is serious about it, and that we take seriously the responsibility that people have to get around safely. So, we are going -- we are going to press the Senate very hard on this and see if we can see if we can get this done.

If we get it done, we have a commitment from the House leadership to get it done in the House, too. I mean, frankly, we would like to see this bill signed by President Obama within the next few days, few weeks before Congress leaves for the election. Whether that is possible or not
time will tell.

So, thank you for what you all do for
the American people, for people that want to ride
buses or trains or light rail or whatever, and we
are grateful to you for serving -- for the advice
that you will give us and for the help that you
will give us in our work to make public
transportation the safest that it can be.

And Peter said I should maybe see if any
of you have any questions or comments you want to
ask either of us or John, too. So anybody have
anything you would like to say, any questions?

Well, no questions about, is there more
money can we get more operating funds?

(Laughter.)

MR. PEARSON: Funding is a question.

But understanding the crises that we are in as far
as the country itself, one of the key factors that
we face every day as far as enforcing safety would
be getting top officials to understand that it is
not a federal mandate but it is a mandate of
operation in general.

And to change that, funding would be of help, but also education and dedication from the regional levels. In the state of Tennessee, I feel that the state SSO person knows more about safety than the actual FTA people in Atlanta, Georgia.

Now, after talking with them, they are going to attend the SSO meeting that is going to be held in Memphis, and it is a little difficult at times that you try to enforce issues and you don't have support from the top.

SECRETARY LaHOOD: I think you make a good point, and part of it is -- and I will let Peter comment on this, too -- I think part of it is the law says that we cannot be involved in this. And, so, I think there has probably been a mind-set, I suspect, at the FTA and at DOT that since the law inhibits us from doing this, that we have not really pressed our people to do it.

But I think our people know now, coming
from me and Peter and others, that safety is a big concern and a priority. And I think if people look at the legislation that we have crafted with our friends on Capitol Hill, you will see that we are serious about this. But I think there has been sort of a mind-set over time, because the law has not allowed us to do this.

MR. ROGOFF: Well, the thing I want to add, I think importantly, I hear what you are saying. And precisely because the FTA has not been in the safety business, we have a very good safety team but a very lean and very small safety team within the FTA.

Obviously -- and I have had a number of conversations with Bill Millar (phonetic) about this, too, our challenge is to raise everybody's game, and that includes the FTA's game. Right now, you are right, we do not have safety designated experts in our regions. That is true in Region 4 in Atlanta as well as Region 5 in Chicago.
But our goal, as we stand up in the regime and as we take the guidance of this group, is to build our resources within the FTA to bring that expertise on, and also to build the resources within the state partners and help fund those state partners in a way we have not in the past, so they can do a better job. And I am talking specifically about the SSOs. And importantly and Bill Millar has been very articulate about this, and I think he's right, although it is not necessarily a cornerstone of our legislation, we need to commit some resources to raising the level of expertise and attention of the operators themselves.

It cannot just be about regulations and enforcement. It needs to be able to, especially with the retiring work force, where we -- the work force that is retiring in increasing numbers that we have the ability and the transit operator themselves have the ability to raise their game with everybody else. But in the end, they are the
ones transporting the passengers. They are the
ones charged with protecting the workers. That is
where the rubber meets the road, and that is where
we need to put our efforts.

MR. PEARSON: Well, one of the key
points that we are trying to make in our operation
is that it is no such thing as an unfunded mandate
when it comes to safety. So, we are just trying
to work on taking the funds from whatever
resources we have to make sure that we not only
say safety is first, but we mean that safety is
first.

SECRETARY LaHOOD: That is a very good
thing to say. I like that, that safety really is
so important that, you know, we just -- and we
know that you all get it. And we are trying to
get it, too. And we are trying to get Congress to
give us some pretty big responsibilities here that
we have not had.

We have had it in the rail business. We
certainly have had it in the airline business.
And we have had it in the automobile industry side of things when we give certain ratings to automobiles for safety and put that out there for people to see. So it seems logical to us, but we, the value of this meeting is to learn from all of you, who do take safety as a number one priority.

Yes, sir.

MR. SUNWALT: I'm glad you mentioned the automobile industry, because it brings a metaphor to the point that I want to make. You know, many, many years ago, the automobile industry fought the air bag and seat belt lobby. And today they claim it and it makes money for them, because they have not only front air bags but side air bags, and they will have top and bottom air bags or whatever would be safer.

Many consensus-driven groups, like I hope this one becomes, deal with minimum standards. And until safety equals money, as in the mentioned example, you are not going to have safety. So perhaps the challenge here is how do
you incentivize rail transit providers to go
above? And since you do have the purse strings
and there is reauthorization pending, perhaps you
can ingrain that incentive.

SECRETARY LaHOOD: Well, look at the
WMATA crash occurred, and it was reported that
they were going to look to us to help them find
some money to replace aging infrastructure,
namely, their cars. You know, one of the things
that we decided very quickly was, give us the
safety plan first, and then we will figure out how
much money it takes to implement the safety plan.

The money should not come first. Safety
should come first. I take your point on this. It
is a good point, but we want to make sure that
safety is the number one priority, and then if we
can incentivize that some way we will, obviously
have a role to play why that also.

MR. ROGOFF: Let me make two quick
points on that. What I think about your remarks
is two things: One, safety is a very high
priority. It is one of the few articulated priority goals of this administration as put out by the Secretary's strategic plan.

State of good repair is another. And if you look at FTA's budget for 2011 currently being debated in Congress, we have observed the largest formula increase that we have under a fairly new budget strictly for state of good repair investments. And I think you are going to continue to see either budgets coming out of this administration a priority on state of good repair funding.

In fact, in the announcement that the President made on Monday, as you look through the fact sheet in which he describes the transit element of the $50 billion infusion that he wants to jump-start authorization with, state of good repair of the systems is specifically called out.

So, we recognize the linkage between state of good repair -- our state of good repair goal and our safety goal. The only thing I would
add, because I think it is important, you happen
to mention air bags. One of the little known
things about the evolution of air bags is, as you
know, Chrysler was the first vehicle, the first
manufacturer to put an air bag in its minivan.
Mr. Iacocca at the time actually was vociferously
fighting having air bags put in Chrysler vehicles.

The reason why Chrysler was the first
manufacturer to put an air bag in its minivan was
they discovered very late in the development of
that model that they were going to fail the
federal standard for frontal crash protection.
The only way they could provide the test dummy
with enough crash protection was to rapidly put
air bag in the vehicle, and that is how they
passed the federal test.

The reason I raised that is to point out
what the role of a minimum federal standard is.
It is important and it has ramifications well
beyond that, because that has, as you pointed out
correctly, started a whole impact where some of
the manufacturers were competing against each
other as to who could get an air bag in their
vehicle faster.

SECRETARY LaHOOD: Anybody else?

Yes, sir. Anybody.

MR. CLARK: Yes, Mr. Secretary.

Peter, nice to see you again.

I'm Rich Clark with the California
Public Utilities Commission. We are incredibly
supportive of what you-all are doing in the
legislative. It is such a wonderful step forward.

I'm very happy to hear from you, Peter,
about the money and that the President was talking
about that is going for state of good repair
issues. That is just absolutely critical. We
have some of the oldest in the nation of transit
systems that really need this sort of money.

Our only concern with the legislation at
this point is that the state preemption issue
seems to have become stronger in the legislation,
as it has come out such that where we are very
concern, we would very much like to have concurrent jurisdiction with you folks over safety. We feel like we are collaborators. We think we have done a very good job in California. And we are very concerned about the preemption language that is in the bill currently. So, if we would have the opportunity to talk about that somewhat, I would greatly appreciate it.

MR. ROGOFF: What I would put out on that is the Administration is building up for its preemption, as you know, the Senate bill does. We will continue to have a dialogue with them about that, as we will with the House.

What we think is most important now is that having had a successful markup in the banking committee, that the legislation move forward through its hurdle, and we are going to continue to have a dialogue both with the banking and the transportation infrastructure committee to obviously capture the essence of the Administration's original proposal. So, we are
happy to --

SECRETARY LaHOOD: The value of what we are doing here this morning and the remainder of the day and tomorrow morning is, you know, collaborating with all of you, you know, so we get it right.

Well, I think I am going to scoot out of here and Peter is going to continue to march forward with all of you. But again, thank you to all of you, each one of you for participating and being a part of this and being helpful to us. And we really consider you full partners in what we are doing at DOT, and I hope you feel the same way. And if you don't, I'm sure you will tell Peter that. Have a good meeting. Thank you.

(Applause.)

MR. ROGOFF: Before he runs out, I also want to thank the Deputy Secretary for joining us here this morning. I think it is important to point out that the whole evolution of our transit rail safety initiative started with the task force
that the Secretary charged the Deputy Secretary with chairing.

It involved contributions from all of the other modal administration with DOT. There were a great many really robust and helpful contributors to that. One of those is here, Jo Strang, chief safety officer to the FRA. We had contributions from many other entities.

It also was -- when we came forward with a rail transit safety proposal for the FTA, it was the first -- the first opportunity for the Secretary's new safety council -- there was a multi-modal DOT safety council some years past. It has been revised and resuscitated by Secretary LaHood. And reviewing and giving comments on our rail transit safety bill was one of the first things that the Secretary's Safety Council has done. And we have taken a great many additional steps since.

I just have a few things I want to add by way of introduction on this important meeting.
One, is to really congratulate all of you and thank you again for your willingness to serve on this important group. You were selected out of among 80 nominees. You were selected because of the diversity and the experience -- your experience that you bring to this charge. Also the diversity of trying to get folks from different parts of the country and different types of transit operations and different steps in the transit safety process.

But importantly, I want to point out while your professional affiliation was a factor in who we selected so we could achieve that diversity, each of you is appointed as an individual. We are asking you to bring us your personal safety expertise and bring it to bear on the specific safety challenges we face.

What we would like to avoid is having people lapse into needing to be the official mouthpiece of their employer on these questions. If that is what we fall into, then I don't think
that we are going to necessarily succeed in
getting consensus on a great many issues.

Just an example of how that is, the case of Georgetta. So, when we first accepted
Georgetta's nomination to be on the advisory committee, she was working for the CPUC. By the
time we had our first meeting, she is working for MARTA, I believe now. But she is staying on the advisory committee, as is all of you, if you change professional position during your term, because again, we will be appointing you to bring your expertise to this challenge, not just to wave the flag of your employer.

Other things I would like to point out and remind people of is sometimes when we talk about the urgency of transit safety legislation, we forget the fact that rail transit safety as a mode is still and remains a very safe mode. We transport eight times as many passengers as does the commuter and freight railroads -- excuse me -- commuter railroads and Amtrak every day. But
those agencies, as you know, are under FRA's rather robust safety regime. This is one of the distinctions that we are trying to work through.

I have said repeatedly that the Administration's goal is not to create the FRA rule book for rail transit agencies. Not only do we not think it would be value added, but importantly, there are some very real distinctions between rail transit agencies and the similarities that you find among commuter rail and Amtrak.

Our challenge is to try to develop minimum standards and safety systems that allow each of the individual rail transit agencies to both be cognizant of and then address their each individual safety vulnerabilities, and those vulnerabilities can differ and will different agency to agency.

It is while transit rail safety is a very safe mode, we do need to be attentive to the fact that our employees, especially experienced employees are retiring in increasing numbers. We
need to be attentive to the fact that our systems are aging, and some of the more modern systems are showing themselves not to be as reliable and durable as originally thought when they were first installed.

And we also need to be cognizant of the fact that some of the systems are becoming more complex, and we need to have a work force that is fully trained and able to handle that complexity.

One of the things I would like to talk about very briefly -- it really it's just a plea, if you will, and that is to stay focused not just on the passengers, but the safety of transit workers. We owe a very important obligation to the workers of the transit agencies that come to work who are committed to delivering the passengers safely every day.

They are also the ones that are most at risk. And we have agencies that have a very strong safety performance in one area and not in the other, and we are determined to address both
simultaneously.

One of the things I would add, you know, when the original prohibition was put into law in 1965 that prohibited the FTA from regulating the area of transit safety, rail transit in America was a very, very different thing. In 1965 there were transit agencies that were paying tens of million of dollars in federal taxes on their annual profits. We don't have that challenge -- which we did, but we don't have that challenge right now.

Rail transit was becoming a very different -- different commuting patterns, very different footprint, very different level of complexity, very different funding regimes on how they were financed. This is a completely different day. And we need a rail transit safety regime that addresses the current day.

I think importantly, the reason why we have stood up as a advisory committee, why we do not yet have rail transit safety authority is so
we can hit the ground running when we get that
authority; that we can be in a place where we want
to already have done a fair bit of our homework
and have a sense of where we are heading. So on
the day that that authority is issued, we know
where we are going, we have work products in
motion.

Obviously, we are not going to take any
measures in advance of getting that authority that
would get us on the wrong side of the law
enforcement. But fortunately, we have an Advisory
Committee Act that allows this group to do a lot
of robust work on where they think we should be
heading while we await the President's signature
on that bill.

So, with that, I'm going to take a step
back. If anyone has any other particular
questions of me, I'm happy to answer them now.
Otherwise, I would like to do away with the podium
and sit at the table. I think we are going to
take time, go around the room one by one and have
each of the advisory committee members give a brief introduction and brief you on how they see our process going forward. Thanks.

MR. FLANIGON: Although we did a short introduction around the table on the committee before our leadership got here, I think it would be worthwhile to repeat that for Peter's benefit before he starts having a dialogue with you all about what he is going to be asking you to do.

And I wanted to add to the committee, we have, I think the best term is ex officio members present. Peter already mentioned Jo Strang with the Federal Railroad Administration. Another ex officio organization is the NTSB with Jim Southworth.

So, if we could do the quick repeat of those self-introductions, along with that added information of where -- what you see as our tasks as we move forward. And we will start again on my left with Mr. Pearson.

And for the record, I do have my cell
phone turned off.

MR. PEARSON: Well, good morning again. I'm Alvin Pearson, the assistant general manager of operations at Memphis Area Transit Authority, MATA. I have been in transportation for now 34 years. I have done everything from railroading to senior citizens public transportation to being the state director of public transportation rail and the water.

And I think this is a great honor, and I am very well pleased and proud of what Secretary LaHood is trying to do, along with Mike and Administrator Peter Rogoff.

I think that one of the things that -- one of the first thing I probably bring to the table is honestly and truth. I'm not one to be politically correct at all times, but I try to make sure that what I say I have supporting documentation to support that.

There are going to be issues with funding. I think you are going to be able to take
care of those issues once we get the format laid. I'm here to participate in laying that format. I think the expertise that I bring to the table would be my affiliations with state governments, my affiliation with other transit entities to express with you the day-to-day crises that we have, as well as my knowledge from starting at the bottom at the railroad working my way up to the top.

And if honesty is not what you want, I may not be the person. But I feel that that is part of our problem now, I think that we need to be honest, upfront and have a working agreement to work it out no matter what.

So I thank you for this opportunity.

MR. DOUGHERTY: Good morning again, Jim Dougherty, chief safety officer at WMATA. I actually pretty recently started that position. I have been in the transit industry, starting in Cleveland, since 1981, so about 29 years. Of the 29 years, 26 years in the transit transportation
safety.

I also hold a position on the board of directors of the National Safety Council and as the vice president of the Transportation Safety Institute. So, I have a lot of interworkings with transit -- well, with safety professionals from all around the world, not only in the transit business. But one of the things we look to bring forward is hopefully, not only the raising of the status of safety, I guess, in the agencies that we work for within the transit business, I should say, but also as far as looking to what we can do to establish some consistency, you know, in regulations.

It has been mentioned the minimum regulations, but I'm hoping that we, with the bill passage, that it would establish consistency throughout the country, and the regulations, that will certainly help all of us as we are building our safety programs and continue to build our safety programs, or in my case, we are kind of
starting over with some of the safety programs
with WMATA and instilling, you know, safety as the
primary focus.

I would like to certainly say focus to
kind of keep the eye on the ball, but we really
need to do things safely. State of good repair, I
believe, plays into the safety. That helps us
with our infrastructure, but we still have
training, and I think there is a lot of training
we can share in the safety training and the
training for consistency that we actually provide
in the transportation business.

I am looking forward to working with the
committee. It is an exciting and honorable
opportunity and certainly, I believe, bring the
integrity. As Mr. Pearson had mentioned, I think
we need to be open.

One of the things I had not mentioned, I
did also serve 22 years as a sworn police officer
in northeast Ohio, along with my transit safety
job. So, I kind of have -- that was kind of, I
guess, an unfortunate perspective, I guess, if you will, but certainly enjoy that and look forward to working with everyone. Thank you.

MR. ROGOFF: Let me point out, Jim's nomination came to -- I think it is on now, thanks -- when he was still in San Francisco. So while I mentioned Georgetta's instance, this is another instance where we bring a professional on board with us, and his challenge -- who has changed jobs and he is still with us. Thanks.

MS. McCOMBE: Good morning again. My name is Pamela McCombe. And I have a different background. I'm a professional engineer, and I am Canadian, and I have a Canadian experience to bring to the table. I have been in the U.S. for 11 years and have worked for two different transit agencies in the U.S., and I have over 25 years experience in public transportation, particularly transit.

I know that we will be looking at different models today, and one of the things that
I would like to emphasize is that the regulation has some very good components to it. I feel that one of the main problems is that it is not consistent -- the application of it is not consistent across the country. And I think that that poses problems, and that is where the FTA can step in to ensure that there is consistency from the state safety oversight agencies.

You have some agencies that have inspections; some do not; some are simply just pushing the paper, so to speak. That has to change.

The other issue is knowledge. Some transit agency oversight agencies have good knowledge; some don't. We have to have a consistent almost accreditation to state safety over state agencies. But that also applies to the agencies themselves.

The safety personnel at the agencies also should receive the same type of training and also should be conducting inspections as well and
doing detailed audits. So it not only should be at the state oversight level, but it all should be at the agency level.

So those are the two main issues. There are other issues with emerging technologies and funding to the agency for the safety groups so that they can test emerging technologies, and where there is training and knowledge required, that there is funding available. Thank you.

MR. CHENG: Hello again. My name is Eric Cheng from Utah Department of Transportation. I have been working with Utah for 22 years, previous experience including I was a safety study research engineer for the department and also as a state safety oversight program manager for 10 years.

It is a great honor to be involved in this committee. And I have some exposure to Asian countries' safety programs. I would like to make a point to this committee that I think I also talk to UTA people, so some of them and me myself
believe we should also look at other countries' safety programs and see how they are doing it, especially in Europe. You know, in Europe they have some good systems; Japan, Hong Kong, Taiwan, China. We need to take this opportunity to review their programs and learn from them.

Another thing is that, I have been, since my involvement with the safety analysis, although now at (inaudible) transit we have data. We have better safety database, but I feel we don't use that data in our analysis effectively. I think we should use the data to find the problem, identify the problems on the highway side.

Of course, you can see (inaudible) most of the research everything is mostly on the highway side. The transit side we have TCRP. But compare the highway side it is very, very minimum. Of course, as we know, transit is a safer system, but I feel we still need that data to improve safety. Thank you.
MR. CLARK:  Good morning again, Richard Clark with the California Public Utilities Commission, director of consumer protection and safety. I, too, bring a unique perspective. I started out -- safety was ingrained in me very early on as a child. I grew you on a fairly large farm, where we dealt with all of manner of danger and hazard. As a matter of fact, the second most dangerous industry in the United States is farming; first being deep-sea fishing, which is kind of like farming on the ocean, really.

In my current position for the last 10 years, I have been responsible for electric safety and natural gas safety, communication safety, freight and railroad safety intercity and rail crossing safety. And prior to that, for 26 years, I did labor law enforcement as a investigator for the Labor Commissioner in the state of California and 13 years running my own private investigations agency, where my clients were labor unions, labor unit trust funds, labor management cooperation
committees, et cetera.

I think that there really are two very important components to improving safety. One, of course, is the fundamental rules that people must comply with in order to operate systems safely. But I think those rules need to be ensconced in a safety culture within an organization where everybody is watching out for themselves and for everyone else, that they are situationally aware and mindful of what their actions are, what the action of others are.

And I was very impressed with the reading and preparation of this. I was very thankful for it and impressed by the approach by the Federal Aviation Administration, particularly when it comes to safety culture. And with that, I look forward to the conversations and the learning that will go on here in this TRACS committee. And again, I'm honored to be a member and thank you very much.

MR. KRISAK: Good morning again, Rich
Krisak with MARTA, HM of rail operations and development. I have been in the rail transit area for 31 years in my career. I started out as a train operator running trains in New Jersey, so I have a very practical knowledge of application of safety and actually doing your job on a daily basis.

I have had the opportunity to work the design, planning and development and the starting of the three rail systems. So I have plenty of experience in that area.

I guess the major concerns for me and issues -- and I think we heard a couple of them already is number one, a standard level of certification training and knowledge. To call yourself a state safety oversight official what does that mean? And I think the state safety oversight agencies that I have worked for in the states I have been in that is very inconsistent.

There isn't a certification process. There isn't a particular body of knowledge to be
state safety oversight -- to head up that function for a state. I think that is really a problem that is a deficit. As well as even inside our industry, even with the agencies there is no consistent level of expertise training or knowledge base that I have to have to function in that position.

You know, we have given some examples of some material to read about the FAA. And I think one of the differences is you do see there is a certain expectation, a level of knowledge and training for an FAA official based on your level in the organization. We don't really have that in transit. I think that is a real deficit to us.

The other thing that I have heard over my career from different federal agency, as a matter of fact, is in terms of design, there are no standards. We don't have any regulations.

To a degree I guess I agree with that, but on the other hand, I think there are some standards. Practices that we all pretty much
follow, NFPA 130 being one of them, I think those are guidelines most of us follow. The start-ups I have been, we look very closely at California PUC, the general order, which is a pretty good starting point. So we look very closely at that in terms of grade crossing protection, single systems based on speed and operating environments.

So, there are standards that are out there. Of course, they are not uniformly applied. So, I think a lot of the body of material and knowledge exist. It probably just needs to be, you know, codified and regulated, because I think a lot of us do that already, and really wouldn't have a problem applying it if we were required to.

And, again, I think incentivizing through funding is a big part of it as well.

MR. ROGOFF: I want to point something out very quickly, I feel like a school teacher that has to separate the children. But while we do happen to have two representatives from MARTA because Georgetta changed jobs, you really should
not be allowed to sit next to one another.

(Laughter)

MR. ROGOFF: We will fix that next.

MS. GREGORY: Well, actually in response to that, I was taking advantage of these 2 days to learn from my peer here Mr. Krisak, because my first 3 weeks at MARTA has been a total whirlwind. We do have a lot of executive meetings. So, there was a reason -- there was a purpose in me sitting next to Rich.

Good morning. I'm Georgetta Gregory. I'm the brand new AGM safety and quality assurance at MARTA. Prior to that, I was with the California Public Utilities Commission, where I was the program manager for the rail transit and crossings branch.

Most of my background, however, is in railroading, mostly in the operations department, over 30 years with Southern Pacific and Union Pacific. So my background is a very practical hands-on working knowledge.
I must say that I'm both honored and humbled to be here at this esteemed table, and I wish I could say that I had brought more to the table, but I think that my participation is going to be more my benefit than yours. My predecessors here at the table have very eloquently summed up the tasks that we have in hand, and not to just be redundant and repeat those things, I'm really looking forward to taking some of the mystique out of this safety culture that we are all so versed in throwing about.

We need to take the mystique out of that, put it in black and white, share it with our peers and put those tools and those philosophies to work so that our patrons, our employees and the entire nation is a safer place to ride around in. I think we are on the cusp of a great transition in this wonderful nation in the world of public transportation.

I personally am very excited to be part of this and really look forward to working with
this committee to help mold and develop the baselines, the minimums. And I agree with Rich, we need standards, not over cumbersome minimum standards, but a reference, if you will. There is no where to go and get a degree in public transportation, so there is a profound need, and I look forward to being a part of that development. Thank you.

MR. HARTBERG: Good morning once again. My name is Henry Hartberg. I'm the senior manager of operations safety at Dallas Area Rapid Transit. That is a position I have held for since 1983, so October would be 27 years. All together, before that, with other things I have about 40 years of transportation of one kind or another.

I took over the bus safety at DART in 1991 before we had any rail out there. And before that, my perspective would be, and I'm still proud to say I started with what was then DTS and now is DART as a bus operator. So I have been one of those guys that works his way up through the ranks
over the years and been very fortunate.

When rail came along, and Richard Krisak will remember this, DART decided that they couldn't really -- I had no rail experience whatsoever. And I must say I never applied for a position on rail. However, DART figured out that they didn't -- they didn't feel like they could afford a real safety person, so they came to me and told me that they wanted me to do it. Thus I became DART's blue light special.

(Laughter.)

MR. HARTBERG: But I worked hard at it over the years. And with the help of Richard Krisak and much of his people, they taught me what was sometimes very painful lessons about system safety and the role that it would play. And over the years, we have developed a system safety process that we are very proud of and that has been pretty much incorporated into the culture at DART.

It is not perfect, but we had a visit
from the Office of Inspector General, as some of the other properties in this room did, and during that period of time what I discovered was, first of all, I had the support of executive management like you wouldn't believe. I don't know, maybe that is in part because they are afraid of the OIG, but they were in the room.

And what I realized, we really had made some progress when I discovered I didn't have to say much. I had executive management in the room explaining to the OIG how our system safety process worked, forwards, backwards, up and down.

So my concern with what we are doing or one of the things that will be a focus of mine is the whole notion of safety culture that we talk about, and hoping that within the realms of rulemaking and things that occur once we have regulatory authority, that we make sure that we have training and understanding and a method that will engage executive management of not just in being able to say I'm all for safety, but
understanding exactly how that process works within their own organizations. So, those are things that I find very, very important.

The consistency of state safety oversight has been kind of beaten to death. We all know that under the process as it is now, I don't know how you can get that uniformity without some form of regulation to guide it.

So, those are the things, some of the things I'm interested in, and I feel very honored to be on this panel. And I thank you all and I thank very much for allowing me to be here.

MR. HARDY: Good morning, everybody. First of all, my name is Leonard Hardy. I work for the San Francisco Bay Area Rapid Transit District, commonly known as BART. I have been with BART for roughly 10 years. I started as manager of operations and safety, and became chief safety office for the district a couple years after that.

Now, prior to working for BART, I worked
for the California Public Utilities Commission. I also was an engineer there, started off as an engineer, and I worked mainly in the rail transit safety section. And while with PUC, I was involved in the first round of the FTA state safety oversight Part 659.

And that involved government regulations for the PUC in the form of a standard that came out by the Commission. It also involved working with the transit agencies and the first formal development and submittal of their systems safety program plans and security plans.

So, I feel like I have had the benefit, if you will, of the experience of seeing the effects of regulation both from the regulatory point of view, also from the end user of transit agency.

Now, with respect to TRACS, first of all, I appreciate very much being selected to serve on this panel. And, you know, if I think about what I would like to get out of this, it
would be easy to slip into development of regulations at a very complex, if you will, and cumbersome for the industry.

So, I think, however, it is more difficult to develop regulations that are not only effective, but that are also simple, clear and practical to implement. And I think I should strive for that, to try to get simple, clear practical and effective regulations.

I look forward to working with this group very much. I think it is diversified with different backgrounds, and I think we will learn a lot from each other as we go through this process. And finally, I hope at the end of this term, if you will, that we will provide sound and helpful advice to the FTA.

MS. BRIDGES: My name is Bernadette Bridges. I work for Maryland Transit Administration, and I have been in transit for 25 years. I began my career as a transit operator and went on the rail side as a rail supervisor and
train controller, and then went to the office of safety, where I have been for 10 years. I work as a safety officer, and I have been executive director for approximately year and-a-half.

I think what I bring to the table is -- I guess my familiarization with dealing with management on safety issues, capital projects, system safety for capital projects. That would be something that we have done, some of the challenges that we faced, the implementation of system safety management plans and plans that we have in place.

I think some of the challenges that we face at MTA are things that we face around the country. And I could go and repeat all the things that everybody said before, but again, it is consistency that we don't have in transit.

I also bring to the table first line experience with operators and managers and some of the challenges that we face training our staff or the managers or the employees and nationally
integrating safety into the capital projects, end projects. So those are some of the things that I bring to the table, I'm looking forward to working with everyone. Thank you.

MR. PRENDERGAST: I'm Tom Prendergast, president of New York City Transit. I'm sitting in for Linda Kleinbaum. There are a number of people in the MTA family that have established safety backgrounds, and Linda is going to be our rep, her role is support.

I have been in the transit profession 35 years, 10 of which were in safety positions at the start of the Transit Authority, the MTA predecessor (inaudible) and qualification, and then New York City Transit. I also was 5 years president of Long Island Rail Road.

I agree with everything all the other committee members have stated with respect to what we need to focus on.

I'm also chairman of the Standards Development & Oversight Committee or APTA. And
that has been a long-standing desire of mine to be able to get to a point where the industry can have standards. Started this process 30 years ago. The smaller set of properties that we had, we are always fighting with each other, saying that you couldn't develop standards that would be applicable across all the agencies. You know, different track ages, different -- all these other arguments.

But we were able to get to a point now where we are developing effective standards, and I agree with Ed's comment that we used the word "minimum," but it really is better to say something that is an established floor that all of the properties can look -- that are practical, that are simple, that are understandable, but that provide a frame of reference for people to aspire to and live within.

I also believe I agree with the Administrator that you don't want to automatically determine what sites is all regulatory
environment. But I would say there are some things about some of the processes and procedures that the FRA has in terms of rulemaking and in terms of joint consensus development toward a standard that people accept that provides a level of consistency that we need to get to in this industry. And I would like to see the committee, and a lot of people here have already stated that those are important things.

The last thing I would like to say is that it is very important, and two or three of the committee members stated it, it has to get to the level where the senior executives of the agencies all receive their executives can literally at the same level of detail that the safety officer can explain the requirements for responsibilities, and that it truly gets to the point, because when all the employees know the person in charge of the agency makes it a priority, it will become their priority.

This is a very esteemed group. I'm very
humble to be here as well, and I will support
Linda as she participates as a committee member.

MR. INCLIMA: Good morning again. My
name is Rick Inclima. I'm director of safety for
the Brotherhood of Maintenance of Way Employes
Division. Just as a little piece of background,
I, like many of you, came from the bottom up. I
hired on as a trackman with the Penn Central
Railroad way back when, and worked my way up,
spent 16 years out the track, mostly on the
northeast corridor, where we run essentially the
fastest trains in the country.

I have had about a equal number of
years, 16 or so, full-time staff with the BMWE
with primary responsibilities for safety.

Hopefully what I bring to the table is
that practical experience and hands-on background.
I'm also a voting member of the Rail Safety
Advisory Committee, which is the RSAC the FRA
rulemaking committee, somewhat corollary to this
group, and I have sat on dozens of working groups
and dozens of task forces, and I probably have the
scars to show.

But I would say with that, that the
collaborative process, the process of
consensus-based rulemaking which are data driven,
which are well flushed out, is, I think, far
superior to having an agency post stuff on the
wall and we all throw darts at the Federal
Register (inaudible). At the end of the day, you
get something that maybe nobody is comfortable
with and nobody likes.

So the beauty of the collaborative,
consensus-based is you get your input on the front
end and. We can all be honest, we will argue, we
will bang head, we will have agreements and
disagreements. But in the end, through good faith
and through all hands on the same goal, we get to
that place where we make sense of the chaos and
come up with a good set of guidelines, good set of
regulatory base of floor, if you will, to improve,
transit safety in the same way that we have done
that in the FRA or through the general rail
system.

    Something was said earlier today, I
believe by the Secretary, that I think is
important, and that is that the worker safety is
as important a focus as operational safety,
passenger safety. You can't do one without the
other. If you kill a passenger, God forbid, very
bad outcomes. Workers, same thing, there is
something wrong when you have that type of a
situation.

    So, I certainly hope to focus on both
aspects. And I'm sure everybody in the room will.
Worker safety and passenger safety as well as
transit safety; the way I see it is very simple
language.

    Certainly I look forward to working with
you all and sharing expertise and experiences,
getting to where we all would like to be, And like
we said earlier, making the transit system in U.S.
the best in the world.
Just as a little editorial comment, the Brotherhood of Maintenance of Way Employes Division, the word "employee" has as in the name is actually spelled with one "E". And the reason for that is we formed back in 1887 as an organization and merged with the Canadian maintenance way workers in 1901.

And as a nod, if you will, a little historical background to our roots, we have left the employees spell with one "E," which is the old English spelling. So, I will make a deal with you-all tonight, when it says Brotherhood of Maintenance of Way Employes with one "E," don't take offense to that, and I won't take offense when you correct it to two "E's". It is all good.

Thank you very much. We look forward to working with you all. Thank you, Peter.

MR. SOUTHWORTH: I'm ex officio member of the (inaudible) my name is Jim Southworth. I'm the chief of the railroad division at the National Transportation Safety Board. I have
responsibility for the overall management of rail related investigations.

Another activity of my investigator (inaudible) and outreach. Fifth generation railroader, my career is pretty well split, I don't want to leave anything out. I have spent about 15 years at the Association of American Railroads in various positions working with all (inaudible) class one and so forth under FRA regulations.

We are, of course, very supportive of the establishment and the enforcement here of minimum federal safety rail transit and those carry -- are not already regulated by the FRA.

I look forward to helping out with the discussions, answering any questions that may be about our agency's work. I have made a couple of trips this year, one to Philadelphia in April, and one to Boston last month in August to talk a little bit about how we conduct our investigations and what they can expect from the NTSB (inaudible)
policy and also process (inaudible) from the
development of and the recommendations.

I'm also happy that there is an
opportunity this afternoon to talk about safety
plan modules. Our member Mr. Sunwalt, will be
participating in that portion of today's
activities.

I would like to point out also today
with us this morning is my new boss Steve (inaudible), right back here. He became the
director of the Railroad, Pipeline and Hazardous
Materials Investigations office of which I work
for. And I am happy to work with Steve. So you
get a chance to see him. Many of you already know
him. He spent almost, I guess, three decades in
the industry, (inaudible) New Jersey Transits.
I'm glad to be here and help out in any way I can.

MS. KOVALAN: Thank you. Good morning.
Again, my name is Amy Kovalan, and I'm with the
Chicago Transit Authority. Perhaps what I bring
to the table is a fresh look into transit, which
is what I brought to CTA which I joined just over 2 years ago.

My background is a little bit different. It is a legal compliance risk management and audit. So an important component of when I joined the CTA safety team is the (inaudible) it was a process from how to (inaudible) about safety. What I really learned is that there are some key things that needed to be done in order for me to be there, which is (inaudible) of why I was hired and I'm sure you are, too. We need to be out there in the middle of the night when something goes wrong, we need to be talking to people when something doesn't go wrong (inaudible) and you need to be out there and seeing when things go right, so you need to be out there. When you are out there you need to listen and you need to watch.

And I think that talking about safety culture and talking about employees is really the right place to start. There are layers to safety
in all of our information and our industry. And when something catastrophic happens, it is not because the operator on the line was the last credible mistake, it is because there were many, many issues leading up to that last critical moment.

And, so, I think recognizing that in our industry as other industries have, I enjoyed the previous as well, as there is a lot of to be learn in how the airline industry brought down their catastrophic accident numbers over the last 30 years, 40 years, and a lot of that came through training, through resource management, human factors (inaudible) training for people who make critical decision.

One of my favorite things to play for people is the tape of the pilot who landed the plane in the river in New York. When you listen to his process and how calm he is and how he makes decisions, how he evaluates his actions, and then makes the last best decision based on the options
that he is provided, I think the industry -- our
industry can learn a lot from that.

I will feel better about our safety
program when I (inaudible) frontline (inaudible)
the level of training and simulation that the
employees in the airline industry get.

I also think that there is a critical
need between risk litigation, state of good repair
and funding. I know that the FTA is focused in on
that and finally telling people that you need to
make our systems 100 percent safe. You are going
to run trains. You are going to move (inaudible)
people a day. Things are going to happen.

So what we really need to do is figure
out what is the risk appetite, what are the pros
and cons. When we run a very old system it
doesn't mean it can't be safe. Sometimes in more
complex system raise different safety challenges.
But if you are going to run a system, it has to be
in a state of good repair in order to run safely.

And then finally I wanted to talk about
the notion of a minimum standard. I think that, as has been said, there are many things that we can do in our industry to set minimum standards. And certainly coming out of a compliance background, I'm a strong believer in that. But I do think it is important for this group to have those discussions. Just as an example of NFPA 130 (inaudible) in a new start makes perfect sense. Why would we build a system that didn't meet that standard. STCA (phonetic) if I want to bring my subway system up to NFPA 130 standard, I need to check for billions of dollar, because I need to rebuild my subway, I need to dig ventilation shafts, I need to move utilities, I would need to do a number of things in order to bring it up to that standard.

So while that is an aspirational goal, we need to discuss with the NTSB (inaudible) and expressed in 2006 it is not something that is achievable. It is a very, very large check. And as we look at that, you have to weigh that versus
other critical needs that also impact safety. So important interaction between minimum standard and creating safety operating systems is understanding what the individual risk ratings are for each of the things in your system. And we try to do that through our legislative process.

And that is another component to think about, how do we allocate our funding decisions along those safety risk lines. These are the types of things that we are working on, and I hope to share it with the group. Thank you.

MS. JETER: Good morning. My name is Jackie Jeter. I am president of the local here that represents the transit workers here in Washington, D.C. Many of you I have met through the NTSB hearing and all of the publicity that has been surrounding the June 22nd accident and the accident that followed.

I think some of what I hope to bring to this committee is the perspective of workers. I was very glad to hear the Secretary talk about the
fact that passenger safety is not only the first priority, it should also be worker protection. And if there is one thing that I know that has caused some of the sleepless nights that all of us encounter in transit is the worker protection.

I think we all here in the United States must change the culture in which we do business. That is what the FTA is trying to do with regulations. That is what we are trying to do here at WMATA. And I feel safer with public transportation, but it is also I need to feel that comfort that I know each and every one of my workers and my members will go home every night to their families because we do run safe systems. So, we have to get in the mind-set.

Oftentimes as managers of public transportation systems, you think about the bottom dollar, and safety is always cut first. If safety is cut first, then I can't go to sleep at nights, because I know that the workers that I represent cannot go home. So, I think that we need to
change that mind-set. We need to change it quickly. And I hope to do so or help to do so and look forward to that opportunity.

MR. WATT: Thank you. My name is Ed Watt. I started working for the UC Transit in 1980. Very close to a year after I started there, one of my coworkers was killed on the job. I went to my first union meeting after that. It made safety very personal to me. I spent 9 years as the number two officer in Local 100 which 95 percent members work for the MTA in New York City.

In this capacity now as the director of health and safety for the Transport Workers Union, I get a lot of exposure from both air and rail. They have great or at least better collaborative models that I think we should look at in term of process. We represent 40 or 50,000 American Airlines workers, as well as the ground crew and the -- excuse me -- the baggage ramp crew and the flight attendants at Southwest Airlines, one of
the only profitable and growing airlines in the
country and one that is very proud to say that it
is (inaudible) for more than 30 years.

I mentioned the air and the rail because
I, too, like Tom have a backup team and a support
team of people for both rail and air who are very
active in the rulemaking processes. And I think
that although there are differences in transit
rail, you can't apply this or you shouldn't strive
to apply that, that there are many similarities
to. All of these industries are schedule driven
by legal standards, medical standards and
(inaudible). They all have production. So there
are things that we learn from them, as well as
from international sources.

Some of the consensus-driven components
in these processes are mutual trust, candor and
willingness to share information. I think that is
important. It cannot be overstated in the work
that we are about to undertake.

There are also four other important
items to mention. First of all, all the stakeholders are at the table, so I'm glad to see the diversity here, especially to see that there are consumers at the table. Getting the rider's perspective is extremely important.

It should be assisted by other professionals such OSHA and (inaudible) people who have invented this wheel and other wheels several times already, so we should not seek to reinvent that.

There should be knowledge based decisions here. I know a lot of times there is other than knowledge that creeps in. Fortunately and unfortunately at the same time I understand in the private sector if you don't make money -- Southwest people tell me all the time, if planes done fly, we don't make money. So it can't be an obstruction to production, but it has to be balanced.

And lastly, there has to be transparency. That means very frank discussions
on things like on time performance, production, value of the work force and how the economic downturn that we are experiencing now, as well as unfortunate adversarial relations between work forces and management impact safety. Thank you.

MR. BATES: Good morning. My name is William Bates. I'm the District of Columbia legislative rep. What I bring to the table is, as in my title, Amtrak and the United Transportation I am an Amtrak conductor. I'm still working as a conductor. So, I'm one of the workers that you are talking about. So I have a whole different perspective to this committee.

My background, I have been a conductor for 29 years. I have also been a safety engineer for Amtrak, different safety committees with Amtrak. I even won the award for the top safety employee for Amtrak called the Charles Luna award. I serve now the FRA RSAC general rail safety committee task force.

And I just asked that if the agencies
here if you don't have labor at the table talking
to you about safety, you should, because you need
a different perspective. In order to have a safe
operation, you need to have the workers there to
tell you what they see, not what you think you
might see. And I'm very passionate about safety,
because when I first became a conductor, my
mentor, 2 years -- I had been on the railroad for
2 years, and my mentor got both of his legs cut
off. And after that I realized that safety is no
joke.

So this is what I bring to the table.
I'm honored and I'm willing to work with each and
every one of you on this committee. Thank you.

MR. GENOVA: Good morning. David
Genova, assistant general manager of safety,
security and facilities at Regional Transportation
District, Denver. And I have been at RTD about 17
years now, with a large (inaudible) emphasis on
operation maintenance emphasis. But also we have
had the opportunity to do a lot of expansion in
our system, and so a lot of the safety experience I have is with new starts and expansion.

And there has been a couple of mentions of minimum standards, minimum requirement, Richard started that dialogue there, and that is an area I would like to address. But overall, I think that this is an incredible opportunity for this group to have some input into meaningful and practical regulations.

Many of us kind of grew up with the state taking oversight rules. We know what works effectively, what elements of that program work well and what elements really not so well. So I think, again, we just have a great opportunity here for practical and meaningful regulations.

I was also very pleased to see in the proposed legislation pieces on asset management and state of good repair, because frankly, as -- in agencies we talked about maintaining things to the state of good repair. I think what we see around industry around the country is that that
means what we can afford in the short-term. And
unfortunately, I think that we are putting off
some very big dollar investments that are
difficult for us to afford as an industry.

And so speaking to that, that piece on
that asset management and state of good repair,
really gets to another element that I want to
point out from my perspective and my observation
is that I think we have opportunity to have a
greater emphasis through this process for the
planning, design and engineering phase of new
systems.

I appreciate the comments about older
systems and really not being very practical to
bring them up to people who have built a new
systems to, but I think we have really great
opportunity now to set some standards and have a
greater emphasis on the investment that we make at
the outset to be the most appropriate best
investment we make, so that we, therefore, could
actually achieve a state of good repair for our
systems. So, I think will be a very important part of this process. Thank you.

MS. DAVIDSON: My name is Diane Davidson, and I'm the director for the Center of Transportation Analysis at Oak Ridge National Laboratory, which is a DOE federal research organization. I have been there for about 3 years.

And I'm really struck by the culture of safety that exists there. Every management level meeting, whether a director of a division or a center, begins with a safety message. And we, as managers, have to conduct 24 hours of safety observations a year and a minimum number of 24 hours of safety.

So I think the culture of safety is very, very important from folks on the grounds all the way up to executive management. And I have witnessed this in the past. Also worked for the -- was with the National MTA for a few years and then served as the director of rail transit
and waterways for the TCOT. And I was GM for a smaller (inaudible) work of assistant.

Until I worked with a rail safety manager and the rail inspectors I didn't really have an appreciation for the culture of safety. They taught me a lot about the importance of everyone in the organization understanding that safety message.

One thing that I think we are already doing right in this committee and that the FTA is leading us towards looking at models from other organizations, in particular FAA and FRA. But I would also encourage us to look at FMCSA and FILMSA (phonetic), some of those other organizations that safety enforcement is critical to accomplishing their mission also. So, we might want to broaden the frameworks that we look at.

I think at the end of the day what we need to be focused on are consistent, effective and adequate regulatory framework that results in enforcement. And we have to balance the
enforcement with the standards, and in the middle of that will come data driven risk assessment -- I think that has been alluded to -- certification and continuous training, the world of technology and taken advantage of some of the new understanding of not only advanced technology in accomplishing the safety mission, but a few factors. So it necessitates a systems approach.

And listening to the background of my colleagues now on this committee I think we will get there. Thank you.

MR. GRIZARD: Good morning, everyone. Bill Grizard, I'm director of safety for safety programs at APTA, America Public Transportation Association. I had the distinct privilege of being the last one in line, so I can say I agree with everybody else said --

(Laughter.)

MR. GRIZARD: -- but I'm not going to do that. I think there are a couple of things that I will make some observations on.
The first one was I was very glad to hear that Mr. Rogoff and Mr. Millar actually communicate on a safety level and that the message they are getting across -- I guess all of the notes they have been given to Bill Millar affect us and I appreciate that very much. It has not always been that way.

And I think it is very true that every administration that meets would say safety is our top priority and, you know, it ends up being another election. And that goes to one of the things I wanted to talk about, which is sustainability of the effort. I think it is that the tragedies that bring us all here to form this effort, I don't want to see that be a wasted effort. I would like to see it not be a reactive effort, but something that is going to continue long-term. It would be good for the industry, be good for the passengers, be especially good for the employees.

I think our charge is to try to elevate
safety in the industry. And in the whole every area both on the regulatory side and on the industry side. And to make that sustainable so that whoever comes after us can pick up and continue that on.

I also think that we need to look at maybe a little wider perspective than the regulatory perspective while we have an opportunity here to establish framework for regulation. I think that is a primary consideration. But I think there is other claims that we can do out of this type of format that don't necessarily take the shape of a regulation but take the shape of the framework for how we conduct our business and we keep our eye on the promise, don't let the regulation and the minimum standards become a goal. That we continue to address operational risk and that we continue to do that constant improvement that needs to be done in the industry.

And, so, on that regard, I think we need
to create safety as a value in the industry and sustained safety programs and for people on a training, education, all those things that everybody has already mentioned as being a critical factor.

At the risk of running on here and getting between us and the rest of the agenda, I will turn this over to Mr. Flanigon.

MR. FLANIGON: Thanks, everybody. What we will do now is take a quick 10-minute break. And when we come back, Peter is going to talk to you as a group regarding what the initial goals for the committee are. So I have 20 before 11:00, so let's come back at 10 minutes to 11:00.

(Brief recess.)

MR. FLANIGON: Next up on our agenda is to get to the meat of what we want to do over the next day and-a-half. The way I have been describing this to people is we are starting out at 50,000 feet, and over the next day and-a-half, we will get as close as we can to ground level.
So, at this point in the agenda, we resume the conversation with Peter Rogoff on what it is that he as the Administrator is asking the committee to take on. So without further ado, I will turn it over to Peter again. I didn't have to pick up the whole darn thing.

MR. ROGOFF: I don't know. I will take that risk. But I want to just again thank you all and discuss one sort of administrative issue before I lay out the formal tasking to the advisory committee. And following my comments, I'm afraid I have to leave and go back to the building, and I will hand it to the able Chairman Mike Flanigon and to Sean Libberton.

And I should say I am really pleased of the 21 members on the advisory committee who are in attendance of this opening all but three. And I have to admit, with some embarrassment, for two of those individuals their absence is explained by Jewish holiday. I am particular embarrassed as one of the Jewish administrators to have made that
mistake, and I apologized to them, and I apologize
to you-all for not having the benefit of their
participation for very acceptable, understandable
reasons.

I do appreciate Linda sending not just a
surrogate, but a surrogate with extraordinary
experience who could serve on this committee in
his right.

I do want to say as a general rule, we
are really going to push to have more
participation by the principals. We will talk
about this further later, but I think it is very
important, especially if we are going to have
consistency and for the committee to operate as
effectively as it can be, that -- you, know we had
some instances indeed for some of the people who
sought nomination to this committee, one of the
reasons why they might not have been selected was
our concern that they could, in fact, be in a
position to regularly attend the meetings.

So, we look forward to folks regularly
attending, and I will promise on behalf of the FTA that we will do a much better job of being mindful of all of the other issues like religious holidays when we schedule things.

    I now want to discuss my formal tasking to the committee, and if any of you are questioning what the value was of that previous discussion, I have intended to break -- already developed a second one. So, you have one in writing, and I am going to call an audible on the second one, because one of the things that we want to take care of is to do this in a logical order.

    So I'm going to discuss the first tasking that I mentioned and I will read the document which is now before you. It goes to the heart of this issue that many of you talked about this morning, and that is what can we learn from best practices in other agencies and in other modes on the industry side as well as the agency side.

    We have talked continually that the way
one addresses those distinctions between trends of
technologies that we are seeking to improve the
safety performance on and to potentially regulate
how we address the distinctions in technologies,
how we address the distinctions in management
structure, and how we address the distinctions in
financing schemes is to get at what is sometimes
generically referred to as safety management
systems.

Some very positive things have been said
about what the aviation industry has been able to
do. A lot of the concerns and the challenges that
people have talked about this morning, namely,
having senior management totally cognizant of
their safety responsibilities and take them
seriously, having the necessary information as an
agency to actually know what your greatest safety
vulnerability is, the critical involvement of
workers who are daily working on the system and in
forming that picture.

All of those are part of what should be
the ideal safety management systems which we are
going to effectively bring to bear across the
entire rail transit safety universe. We need to
know what we want to identify as best practices
and what we want to put together.

So, in that regard, the first tasking
for the advisory committee is to develop consensus
advice to FTA on the best safety (inaudible) model
for the rail safety industry to include safety
management systems as in its principles and how
those principles might be incorporated into
transit safety plans to enhance rail transit
safety. Also to identify the challenge that it
may be facing implementing this model, along with
potential ways the challenges may be overcome,
issues requiring a specific report which we would
write, with a target date to report to us by
March 15, 2011.

This (inaudible) high reliability
organization and SMS principles be integrated
throughout transit systems, consider the diversity
of rail transit operations around the country, and can the recommended model be scaled to transit systems based on size and complexity. That item is listed as task number 10, which I presume is 2010, number 1. I having to call an audible to articulate number 2.

One thing that is consistent both with car practice and what is envisioned under the Administration’s transit safety bill and what continues to be envisioned, however with a slightly different funding picture in the currently pending banking committee reported Senate bill is the continuation of state partners in doing oversight and enforcement of federal regulations. In this case, obviously, I'm talking about the SSOs, a couple who are represented on this committee.

And we had a very good and I thought valuable discussion going around the table, and people seemed very engaged and interested in getting at the issue of what defines a quality
state safety organization. And it seems to me at this stage knowing that we are going to have state partners under any of the scenarios legislatively, it is not too soon to be talking about what defines the ideal state safety department in terms of their capabilities, in terms of their expertise, in terms of their relationship with the federal government, their relationship with their state government, the funding scheme of the state government and their relationship, obviously, with the transit agencies they would oversee.

And I would like the committee to start off trying to wrestle with that question as well, because that will be important. When people talked a lot about the need for consistency and the need for us to get to a point of certification, well, that is what is envisioned under the legislation, be it the federal -- the Administration's legislation or the Senate bill, the Senate bill would fund the agencies to the tune of 80 percent, while the Administration's
bill will fund to the tune of 100 percent.

The Senate bill would continue to require each state to have such an agency. The Administration's bill envisions a scenario where states, in certain cases, could opt out and have the FTA assume that responsibility in their state.

Those differences will be worked out one way or the other, but in either case, we will have state partners and we are determined to improve them. What the goal should be, what our end state should be as part of that improvement effort I don't think it is too early for us to seek to identify. That is the second tasking to you.

I think I will ask Mike, Sean, and I should identify Bill Millar to the council's table as well, I'm going to ask them to formalize that in the same written document that you have for the first tasking, so that could be shared before your meeting is out.

With that I do need to get back to the building. I do want to thank you again for all of
your participation, and to say hi to some of you that I have not met before. I looked forward to meeting many of you if not as part of this meeting, but during the next meeting. I was hoping to try -- I know that there is a brief reception this evening, I would want to come to that as well, but unfortunately, I am meeting with the Secretary at the identical hour.

And again, thanks for your efforts, thanks for the seriousness and purpose that you all are clearly bringing to this effort, and I think all of the transit passengers will benefit from as a result. Thanks.

(Applause.)

MR. FLANIGON: I can't get this mike out, so I will have to carry this whole thing around.

Thank you, Peter. We appreciate you being here.

This is really an exciting time to be in our shoes, I think, tremendous opportunities to
build on an already good record of the industry. And it is so cool to be where we are right now. I can't -- almost can't get over it.

Next up is going to be Sean Libberton, who is my boss and also the designated federal official, ably assisted by our Deputy Assistant Chief Counsel Linda Ford, to talk a little about the organizational structure.

And maybe I will just add one quick piece on that. One of the things about the Federal Advisory Committee Act is that this is a public meeting. It is open to anyone in the public who would like to sit in. And there are a number of folks, and we are glad you are here. But it is not a public hearing where there is direct interaction at every point in the agenda. We do have a time set aside tomorrow at -- I forget the exact time -- it is 9:00 -- 9:45 for any members of the public who would like to address the committee and share any thoughts that you might have.
So, if there is any members of the public here now who would like to do that, if you would let one of our staff folks know.

Can I also ask -- we didn't go around and introduce anybody, but we have a lot of people from FTA here. Could I have the FTA folks raise their hands. I know there are quite a few. And we are here to help you.

And, Esther, I will ask you -- Esther is way back there with the red -- very nice red jacket. So, if there are any members of the public who would like to make a statement tomorrow at 9:45, please let Esther know, and we will work you into that agenda.

The only other person I would like to just point out for very -- this is special day for Holly, who is with the FTA. It is her birthday today.

(Applause.)

MR. FLANIGON: One of the more kind of interesting things is that Holly's birthday is on
September 9th, which is 9/9, and our meeting today started at 9:00 o'clock, on 9/9, and we are meeting at a hotel that is located at 999 Ninth Street. So, I had to look this up on the internet, so it must be true, the number nine is a particularly lucky number in Chinese culture, an auspicious number, so I think it is a good omen that we are here on 9/9, at 999 Ninth Street.

With that, I will turn it over to my esteemed colleague Sean Libberton.

MR. LIBBERTON: It's not a coincidence, by the way. It was absolutely planned that we hit that lucky number nine --

UNIDENTIFIED SPEAKER: It's not very loud.

MR. LIBBERTON: I have got the light. Can you hear me? Thank you.

And I will explain a little bit what the designated federal official is in a moment. I had to look it up in the reg prior to the meeting.

I, too, want to thank everybody and
welcome everybody who is able to come from, in
many cases, miles and miles away and cut into
vacations to join us for today and tomorrow. I
also want to welcome the public.

A little about bit about me, it is
really unfair for Mike to call me his boss. It is
true that the safety office is under the office of
program management. It also runs the grants
program and oversight engineering program. But
Mike certainly has been more of a teacher and I a
student on the issues of safety. You will see, as
we get to the presentation, that we divided
responsibilities for the task for TRACS to really
take advantage of our capacities.

I want to talk a little bit about the
operations of TRACS, but I do want to put it into
a bit of a context, that is that this is FTA's
first ever standing advisory committee. We have
utilized FACA for negotiating rulemaking and other
ways to reach and operate in full disclosures to
the public. But this is our first advisory
committee, so it is a learning experience for us, as it is for many of you all, although I believe a few TRACS member have been on other committee. So, bear with us there.

I'm going to be talking about how we are going to operate, and these are -- should be viewed an interim procedures. We are in the process of documenting formal procedures, which you will have shortly for full review of the membership. But for now these will be the operating procedures over the next several months.

I will say these operating procedure are entirely consistent with FACA. They are consistent with our charter, and I want to make sure everybody has the copy of the charter, has read the charter. If not we, will get you a copy.

I also want to tag on to Mike's acknowledgement of some FTA staff, because you will get to know several of us as you get to work in the advisory committee. And Mike acknowledged Linda. Holly and Richard Wong work with Linda and
support from the legal perspective and certainly provide me a lot of assistance on backup of clients.

Couple of other people that you will get to know is Bruce Walker and Iyon Rosario (phonetic), who will support you and the working groups as you begin to work and roll up your sleeves and start addressing the challenges that we have before us.

I see (inaudible) in the back who spreadsheet the team leader for the state safety groups. So these are all resources to you and will support you, and we will talk a little bit about that support.

There we go. I'm going to spend just a moment on a FACA 101, talk about the TRACS within that context, again how FTA supports the TRACS advisory committee. We will talk about the process and focus on the working group, that is where much of the work is done.

Peter touched on alternates. I will
provide another point or two on alternates and kind of meeting management protocols, and I will get to that again. But two quick protocols, if I may. One, if you have not already, please silence your cell phone, Mike.

And if you have a comment or question, rather than kind of wave your hand, if you could -- and this is going to be awkward at first, because we are still getting to know each other, but if you could somehow turn your card down or flip them up. I worry --

MR. INCLIMA: Like that?

MR. LIBBERTON: I practiced that earlier, and I couldn't get it to stay, so, if you are more able than, let's do that. But I do prefer that, because I can see your name.

Real quickly, the Federal Advisory Committee Act, passed in 1972, was, you know, very consistent with at the time of opening decision-making to the public and taken out of the bathroom and out of the hands of special interest
or perception of special interest. This is generic sunshine laws, and it is certainly consistent with that.

It is by law advisory committees are established only when there are considered essential for a federal agency to perform -- to carry out a responsibility. So that really gets to the importance of safety to federal transit and improving safety oversight and for your work in support of that. There are only, at any given time, between 900 and 1,000 advisory committees operating at any one time. So you are a very elite, select group.

Some of the objectives of the advisory committees is to provide advice that is relevant and objective. And as Peter noted, you are here to represent yourself and the public interest not your employer or agency. There is a bit of a tension, I would say, built within FACA that we must deal with. But there is tension between openness and public disclosure and the need to be
timely and to be efficient.

And in fact, FACA, you know, says that the outcomes of our work should result in either improvements to service or in-service or reduction in cost. And that a committee can be terminated at any time when the cost of maintaining a committee exceeds the benefit that the Administration believes is getting out of it.

So, we need to be mindful of that. We certainly, as you will see, we will provide a great deal of staff support to TRACS. And you will see that we have a lot of work ahead of us and that there will be pressure to be timely and to be committed through the working groups, through the tasks that Peter has provided us. And obviously to the need to document and disclose to the public, and that, in the large part, is my responsibility.

FACA also ensures, as I mentioned, that it is the public and not interest groups that are part of the process does ensure public notice. It
provides for advance public notice for meetings. It allows the public to attend and participate. And we are obliged to make all committee materials available to the public.

Prevent service by individuals with conflicts of interest. There is no registered lobbyists that are part of the advisory committee. And it gives voice to the dissenters. And we will talk a bit about consensus in the moment. But the idea is to really seek unity on a position, not unanimity, so that we can bring recommendations or not that reflect the consensus of the committee.

So TRACS fits into that how? Well, we have established TRACS to help inform FTA policy making. We have selected you with your knowledge, experience and really the diversity of your perspectives. And I'm very pleased with the mix of talents and experiences and perspectives that you all bring, and we will see if we can bring more of those experiences to our future work.

So I want to talk about how FTA --
before I get into TRACS operation, how FTA specifically supports your work. The FTA Administrator recommended the selection of each of you to the Secretary for formal selection to TRACS. He appointed Mike as a chair and myself as the DFO.

I do want to acknowledge Eric Cheng Utah Department of Transportation, who is your vice chair, and will be carrying out an important part of our initiative.

Peter, the FTA Administrator, will assign tasks, as he just did and can withdraw those tasks at his discretion. He may consider TRACS' recommendations in policy and potentially, depending on the legislatim pending any regulatory, regulation following. The designating -- and I have already gotten that wrong, it's the officer, not official, which sounds strange to me, I should have a badge -- really ensures that the committee works within the spirit and law of FACA. That is why Linda is
going to be so valuable to me and to us, as she is really the agency expert in FACA.

So our responsibility is to ensure compliance in some ways on the conduit between the group and the administrator. To ensure that we maintain the records and that meetings -- that the meeting minutes, the products of the group, again, meet FACA requirements and those of the charter and are made available to the public.

Now, in some advisory committees the DFO and the chair are one and the same. We purposely split that so that Mike Flanigon as your chair can really focus on the content and facilitating the meetings and developing the right agenda for our work. In a lot of ways, I'm the bad cop to his good cop, okay. He will facilitate our discussion.

I may step in where I feel that the discussion is lacking and is not in the best of interest for the work of the committee to proceed on a certain track, or to maybe stay on schedule.
Mike doesn't need to worry so much about schedule. That will be my responsibility. So you will hear from me rarely, but you may hear from me.

And, so, Mike is going to run the meeting. It is also important that he is really the liaison between the working groups and TRACS. Many of you -- most of you will be on working groups, but Michael will have that formal kind of liaison function.

I do see any upturned -- oh, I do see one. Yeah, please.

MR. INCLIMA: Just one question before we move off this slide. The first bullet says the chair and the vice chair assigns task. And my question to you is, does this committee as a body have the authority, whether it be by majority or by consensus, to reject the task?

We do have that authority at the RSAC to say we don't -- for whatever reason, we don't want to tackle that. I think that is something -- I mean let's face it, if you force feed us and we
don't want to do it, it's going to be a difficult process.

MR. LIBBERTON: I think if that is, by consensus, the will of the group, then yes.

MR. INCLIMA: Okay. Thank you.

MR. LIBBERTON: I should say, too, that you may suggest tasks to the administrator. And he may decide to then assign them, so to speak. Thank you.

MR. CHENG: Please allow me to say a few words.

When Mike called me regarding the vice chair assignment, basically I -- the first feeling is that I feel that it is a great, great honor to be selected for that position. But I talk to my management. You know, we do have some concern about the time and everything. But honestly, you know, I feel -- I feel everyone else but me, you know, is more qualified than me to be in vice chair. So, if you want to talk to Mike --

(Laughter)
MR. CHENG: -- you are welcome to change this position. Thank you.

MR. LIBBERTON: We think of you as the vice chair.

All right. So we want then to now spend a few minutes on really how we are going to roll up our sleeves and get things done. It is not at these meetings that we spend a lot of time in details. We certainly, as Peter has now tasked us with two assignments, it is going to be very important for us to understand how we work on those assignments and resources -- the format and resources available to do that.

Working groups will be set up to support each task. And you should think of the working groups as staff to TRACS. You will likely participate in those working groups. And we have talked about and we still are developing some parameters. It may be that we will insist that every working group have a minimum of four TRACS members, maybe a maximum. We didn't think that
with just one or even now two tasks that that
would really be a problem.

But as the committee advances and over
time it is likely that there will be multiple
tasks at any one time and, you know, the TRACS
members cannot participate on all of those. But
we do need some support and some direct
participation by TRACS members in the working
group.

The working groups meet as necessary,
and that is really up to the working groups to
decide how often and how those meetings should
take place; if it should be in person, if it
should be a conference call, a video conference.

FTA will facilitate and participate --
people like Bruce and Lyon and others on my staff
will participate and support to the extent
possible. Think of them as that staff support to
facilitate and make those meetings happen. We
will talk with those in a moment.

The outcome of working group meetings
are reports. We have identified a letter report. We will suggest a format for that report. And again, that is part of the process that we are still in development, some standardization and consistency.

It is important to note -- that the TRACS working groups reports to TRACS and not to FTA. And we will talk about that distinction in a moment.

Working groups may further reach out and decide to establish task forces. Again that would involve people of -- members of the group and other resources, other individuals as you see fit. The process for reaching out to identify the working group or identifying additional working group members is for TRACS members to nominate others who they believe will contribute to the task at hand.

I think that is going to be extremely important, specifically for Peter's second task, state partnership. I think it may be to the
benefit to reach out, to solicit and recommend additional state safety oversight practitioners in the performance of that particular task. But that is really left at the discretion of TRACS membership how to basically identify folks nominated to the chair, to Mike, and then he will make formal selection of working group members.

I will pause. I see Rick has a question.

MR. INCLIMA: As we all promulgate in our mind the process, I just have a quick questions.

The first question is, I understood you to say that the TRACS committee members would nominate their subject matter experts or the folks, including themselves, to sit on the working group. Would it be accurate to say that then the working group as a body decides if they need the task force and who sits on it?

MR. LIBBERTON: That is fine.

MR. INCLIMA: I thank you for that.
One word of caution, but certainly based on experience that I would put on the table for the group, I think it would be very important as the working groups begin their deliberations and discussions is to have -- you know, whether it be the chief counsel, the economist, you know, folks in the agency that are actually willing to, at the end of the day, write the rule, write the policy, you need to be in the room and hear all of that deliberation, because a lot -- you know we have seen it more than once where the group reaches a consensus, and then when the consensus kicks out in the final rule, it doesn't look anything like what we thought we all agreed to and understood it to be.

So, it is important that the agency participate, if not actively, at least you know passively, in the process so that you understand the dialogue and the direction and the will of the working group and what they are really recommending.
MS. FORD: I agree 100 percent, and the Chief Counsel has made the commitment to have a lawyer assigned to each working group for that very reason. I'm actually the Assistant Chief Counsel for Legislation and Regulations, so it would be my office that would be responsible for drafting these regulations, and that is why we have Holly and Richard, and I want to acknowledge Mary Lee, who is an honors attorney, who is also providing support.

So, absolutely, we will be on the calls. We will be at the meetings, and we agree with you 100 percent. We have to hear what the committee wants.

And then once we start drafting it, it would come to the committee. So we are hoping to avoid any surprises here, so the committee would draft, you know, the regulatory language as a recommendation to present to the Administrator.

MR. LIBBERTON: It seems -- it is a fine line, in that it is your work, it is the work of
TRACS and the working group. We can support that, but I don't think that we would proactively make recommendations at a staff level to the work of the working group. I just want to clarify that, because again, it's the working group that is reporting to TRACS and not to FTA.

MS. FORD: Correct. But if we have a task and we are tasked with drafting regulatory proposal, then staff would do that for the working group. And go to the working group for approval, and then to come up to TRACS. So, it would follow that process. So, we are hoping to avoid any surprises.

Now, would I bring it to the chair's, you know attention, hey, our working group is kind of going off over here? I think I would. I am FTA staff. But, yes, the process would be, we would work with the working group to accomplish a particular task.

MR. PRENDERGAST: I think Rick stated it very well. There were a couple of instances in
RSAC process, you got to the end game, and the nuances of what the intent of the working group was lost, and the rule got written.

Another example is if you know for a fact you can't go a certain place as an administration, tell us up front, because if you can't get there, it makes no sense wasting all that time going through a consensus process -- there is going to be some heated discussion, maybe not, but -- it is just a waste of people's time.

So, I do appreciate your comment. You don't want to be in the room unduly influencing where it will go. I don't think that is what we want.

MR. INCLIMA: I want to be sure that you are hearing what the group's intent is. You made a very good point. If you can't live with it, then tell us because you know we run into that in other places as well.

MS. FORD: And if I could just say regarding the tasks. You know, we would want to
hear from TRACS as to why a particular task is being rejected. I mean, why you think it wouldn't work. Or if we explained as the administration we are not going go in a particular direction, I think TRACS can still put together a write-up as to why you think it should go in a particular direction.

So, at no point do we want to cut out the opinions or the advice from TRACS during this process.

MR. LIBBERTON: So let's see where we are on this process. We have two tasks that have been assigned to us. We will use the rest of this meeting to discuss those tasks and to discuss the formation of the working groups. We won't have all of the folks identified for those working groups, but we will have some idea of the types of skills and quals that we need in those groups.

We will then have an initial meeting and subsequent meetings of the working groups. Per our charter, those working group meetings will be
open to the public. That really goes beyond -- it goes beyond FACA, which is -- that is not a requirement if the working group is either reporting out to federal agency or the intention is that there is not going to be a discussion by the full committee of a working group's efforts.

Our intention is that the working group bring their products and their recommendations to TRACS for a discussion prior to advancing it to the FTA administrator. Nevertheless, we do intend that that process at those meetings be open to the public.

Once the working group has a report, they then forward that report and recommendations to me. I will ensure that it complies with the task and within FACA requirements and meets our procedure in our charter. And then we will work with Mike to put that product in a discussion, a presentation of this recommendation on the agenda of the next TRACS meeting.

TRACS will then consider at a meeting
like this the working group recommendation. And there are -- I want to read my note to get this correct, there are really three kinds of outcome. That if there is full consensus of the group to accept the working group product as is, it is forwarded to the administrator -- it is forwarded to me and it is then forwarded to the administrator.

It can accept and advance a working group recommendation with some dissenting views, or it can reject the product, the recommendations and send the working group back to work to flush out her direction in the consensus of the group.

In the absence of any consensus on how to proceed to accept or to reject, then the chair will make a decision on how to advance the working group reports.

The full TRACS committee is not the place to rewrite reports. We write recommendations. That is really our work, but it is the purpose of this group to provide the
guidance to the working group to develop, enhance and deliver a product that complies with the task.

MR. GRIZARD: I'm listening to the term "consensus," and I want to get into that just a little bit here in terms of -- the TRACS committee as a group now stands at, what, 22 -- 21. And Mr. Rogoff made the connection that, you know, not everybody is necessarily -- you know, we are going to try to get everybody to attend, but it is on their own dime type of thing and, of course, scheduling and priorities and things like board of director meetings, stuff like that get in the way, as well as religious holidays.

So, in terms of voting, do you have to be present in order to vote? Is there a quorum that you have to be present to maintain? And then is the consensus based on the people available voting at the time or is it for the entire group? And what would the consensus levels be? Would they have to be complete 100 percent consensus here or is 75 good, and 66 better and 50 percent
okay? How are you going to break it down?

MR. LIBBERTON: Let me break down the questions.

You must be at a meeting and you must be a member and not an alternate. We will get into alternates the next slide. But it is only the members who can provide consensus.

We can -- I believe it is the DFO's call to -- if there is a meeting where there is not sufficient TRACS membership to really reflect the true consensus; in other words, if there are several alternates, we could delay the poling of consensus for -- at a later time. And you would have to work out how that occurs.

You know, consensus, what we are trying to achieve with consensus is a position that meets most and the spirit of will of the group. There can be recommendations. So perhaps there are recommendations that don't achieve the unanimous approval or acceptance by the group, and consensus being working and at least trying to see if there
is a way of recommendation to be revised so that it does meet the expectations or the consensus of the group.

You can dissent -- I'm sorry. You can abstain. That does not equal a dissention. So typically, we would expect that dissent would only be exercised if a member feels very, very strongly about a position.

We can move forward without full consensus. And it is notable that, you know, part of the process is that dissention is recognized and noted and decided upon if we move forward with the recommendation.

Linda, I don't know if you have anything to add (inaudible) about dissention.

I will take a question.

MR. INCLIMA: Thank you, Sean. Again, I apologize to the members for having question after question, but, you know, I have some experience a lot of experience in the RSAC, and that is my frame of reference.
For clarity -- to clarify for the group
I would suggest several things. First off, you
have basically three levels of, you know,
committee work. You have the full TRACS, you have
the working group, and you have the task force.
And you may decide consensus in those three
separate arenas may be something different.

In the RSAC process, full consensus of
the people who sit at the table and negotiation is
required to move, you know, that issue up to the
next level. So, at the task level, it is full
consensus, they bring it to the working group
level, they chew on it, they reach full consensus,
they bring their entire full package to the RSAC,
or in this case, the TRACS.

The RSAC works in a process of full
consensus task force working group level, but at
the high level, which would be TRACS here, it is
majority consensus as opposed to full consensus.
And that may be something you want to think of.

There is also an opportunity, and I have
seen it many, many times, and it is not a bad thing, it actually works. If a member feels so strongly at the working group or the task group level that he or she must withhold consensus, for whatever reason, that doesn't mean that entire task, at least in my mind, falls down. That has not been the experience with RSAC.

Basically, you know, that are 20 items on the table, and you agree to 19, and you can move the 19 forward by consensus, you move it up. The one outlier that you can't reach consensus on, the agency just takes that -- you know, takes that on their own and says, well, I have got the benefit of the argument, the dialogue of the groups, and we have heard all of the pros and cons, and, you know, we have to address that issue number 20 and we will do that essentially as an agency, rather than through some consensus recommendation. So, you know, that may be certainly suitable here.

And I think it would help in the big
picture of things, Sean, if we had for the group
to memorialize the, you know, the processes so
that, you know, if you put it in your book and you
realize as new people come in or whatever, okay,
this is what consensus means, this is what we do
with nonconsensus, this is how I handle consenting
opinion to the agency. So, hopefully, you have
all of that in your mind.

MR. LIBBERTON: Thank you. We don't
want to hold up the work of the group for that.
That is something that we are working on that will
help guide your deliberations. These are -- again
interim guidance to you with quite a bit of -- not
intentional -- vagueness as we flush this out.

So I appreciate -- that is a good
example to think about, just because you cannot
reach consensus on several recommendations, it
does not mean the ideas and concepts that have
consensus can't move forward. So, thank you.

Just a moment on alternates. And Peter
noted that, and I believe I seconded it, the
notion of an alternate not necessarily being -- it can be a colleague from an employer, but just remember that that alternate is there representing you and not the agency or institute that you are employed by. Again, you are there for the public interest.

And again, the expectation this is going to be hard and this is a challenge, but it is a challenge I believe that you are aware of when nominated to the group, and we certainly took it into account in our selections, that you are going to make every effort to participate in meetings. That is our expectation. And we understand that this tremendous commitments and challenge that may be just on you on (inaudible).

So, alternates certainly are a resource to you, if you cannot make meetings, but we really expect you to make the meetings. And we will certainly be sensitive to scheduling meetings where we can accommodate the most people as possible.
Alternates cannot provide or block consensus. They are really there to help in the discussion, to report back to their member the sense of the meeting and the issues. And as I mentioned, if there is a meeting where there is not enough membership where we feel that a consensus can be reached, we will delay reaching formal consensus until another time.

MR. PRENDERGAST: There are a lot of people here, and all these people have tremendous responsibilities. And in past committees I've been involved, if for those when you are taking a significant decision, you can provide a means for people to attend the meeting remotely for taking the votes --

MR. LIBBERTON: That's right.

MR. PRENDERGAST: -- that does -- okay. As long as you can clarify that, because that gives people the ability to not find themselves between a rock and a hard place. They want to attend, they don't want to either not be there to
attend to vote, so that would be great if you could do that.

MR. LIBBERTON: Okay. Rick.

MR. INCLIMA: Again, going back to the last slide and the discussion about the alternates' responsibilities for authority. You know, I think you may want to at least reconsider that the alternate -- you know, the third bullet, alternates may not provide or block consensus.

In the RSAC processes, we use alternates all the time at the working group level or even at the full RSAC. And if the member of either, you know, any one of those three levels of the committee designates an alternate to participate in his stead, then that alternate should have the authority to agree with the group or disagree with the group, because otherwise, I mean, you know, as the work really gets going, if you are going to hold off everything going on at the table because there is an alternate here, I really think you are slowing it down.
And it would make sense to allow members to designate their alternates, and you know, that person then acts in the same capacity as the member in his absence or her absence. And personally, I think that is a more fluid process then saying, well, the alternate can participate, but they really don't have a voice and a vote here, you are just kind of a peg sitting in the chair.

And we have to go back -- I mean, when you got a committee this big and getting bigger, it may be detrimental to have that kind of limitations on the authority of an alternate. I just think that you ought to think about that as you develop the written protocols of what the pros and cons of the third bullet are.

MS. FORD: Yes, I hear you, but the limitation here is that -- at the RSAC you represent an organization. Here you represent yourself. And, so, the Administrator made a conscious decision to have that particular
approach as such. You know, we would have to go through bio's and review of your alternates, and that is not something that he wanted to do. So, that is why your alternates reports back to the member.

We are fully aware of the way the RSAC runs. We are fully aware of the voting process within RSAC. But the Administrator made a different decision for this particular group. You are here as an individual, and no one can substitute for you. They can be here, listen, take notes and report back.

So that is just our limitation, and because we have made this commitment to individuals here, it would be extremely difficult to then reverse and go to an organizational structure as the way the RSAC runs.

MR. INCLIMA: Just as a follow-up, is that concept or a policy of the agency, does that flow to all three levels of the TRACS, or is that just for the full TRACS committee?
MS. FORD: Full TRACS committee.

MR. INCLIMA: Okay.

MS. FORD: At the worker level, you can have any --

MR. INCLIMA: You can have alternates, and they can -- really, that is where -- that is where the rubber meets the road and the work gets done. Okay. Thank you.

MR. LIBBERTON: Okay. So just really quickly some ground rules, and we will be all right everybody but me has gotten good at this. Do you have -- I'm sorry, sir, did you have a question?

UNIDENTIFIED SPEAKER: Thank you. Just to follow up quickly on what Rick said. I heard you say take notes, report back and listen. Did they have a voice?

MR. LIBBERTON: Yes, they are part of the discussion. All of the remarks be directed to the chair, or in his absence, the vice chair. I don't think we need to really talk
about respect. I mean, this is a professional
group. I understand that ideas elicit passions,
and I would just remind folks that this is a civil
discussion open to the public. I might remind
you. So, please just use good judgment in the
dialogue. It is important that you negotiate in
good faith and we will do a lot of that.

Again, pagers, does anybody still have a
pager?

MR. INCLIMA: That went out with the
beta tape.

MR. LIBBERTON: And just remember always
the importance of this committee and the work that
you do. And the work and the members of those
working group, you don't have to just be on TRACS
to make a very meaningful contribution to FTA in
how we can improve and enhance the transit safety.

Are there any other questions before I
think we break for lunch.

MR. PRENDERGAST: Are you going to make
copies of these slides available to us?
MR. LIBBERTON: Yes.

MS. DAVIDSON: Can you predict or anticipate the regularity of the TRACS meeting? If we had some advance notification of a schedule, I think it would help with attendance.

MR. LIBBERTON: We know that we will do at least a minimum of two meetings per year, but that could be more. We can certainly I -- guess that is something that we will actually try -- will we actually try to set the next two meetings.

MS. FORD: Yes.

MR. LIBBERTON: And again, that meeting schedule it is identified by the task and the interest and certainly the availability of the TRACS members.

MR. INCLIMA: Before we break for lunch, just as a housekeeping question, will the room be secure -- I mean, a number of folks have laptop and things, or should we take our laptops and all with us?

MR. LIBBERTON: We will be here.
MR. INCLIMA: Somebody will be here.

Okay. Thank you.

MR. LIBBERTON: And actually, thank you for asking that, simply so I can recognize Bob Adduci and several of his colleagues from the Volpe Center, who are providing us with support and providing you -- so we will get to know Bob as well.

Okay, Mr. Chair.

MR. FLANIGON: All right. Well, thank you, Sean. Thank you, Linda. Thanks, everybody, for your good questions and comments. And now here it is -- we can't go yet, it is not noon we have 2 minutes. It is just about 12:00. Our schedule calls for us to start up again at 1:30 sharp, so we are on our own for lunch. I don't know the neighborhood that well. I know there are an awful lot of restaurants pretty close by. So we will see you at 1:30.

(The luncheon recess occurred from 11:58 a.m., to 1:30 p.m.)
MR. FLANIGON: We are kicking off our afternoon session. We are very fortunate to have three very knowledgeable individuals to talk about safety planning models and elements of models, programs and plans and policies and procedures that can work to take organizations to the next level.

One of the things that I like to say about safety management is that good safety management is really just good management, that you can't separate the two. And I think that is going to come through with what we are talking about.

First up is Robert Sunwalt, who is an appointed member of the National Transportation Safety Board. He is appointed by the President and has previously served as vice chairman, had a long career in aviation safety, has been a pilot with US Airways, Piedmont, has run the flight safety department. He has worked with NASA in
developing aviation safety reporting systems. He has co-authored a number of books and over 85 articles in aviation safety.

And one of the things that ties him into the transit world is he has served as the chairman of the board of inquiry into the recent WMATA accident. And one of the things he mentioned to me as we were talking earlier is that as the chairman of that board of inquiry, he really pushed for getting the top leadership of the various organizations to be at the hearing and testify at the hearing. And there was a theme that I think you are going to hear throughout these presentations about safety starting at the top, and we have already talked about it today. So, I think this is the choir that you will be preaching to on this.

And he also organized, as the last day of that hearing for those of you who might have tuned in, an educational session on how you (inaudible) reliability organization, which is how
I came to know Mr. Earl Carnes, who will talk to you later.

So, without further ado, I want to turn this over to Robert Sunwalt. Thank you.

MR. SUNWALT: Mike, thank you very much.

I wondered where you got all that information about me. It occurred to me that I'm the one who wrote it.

(Laughter.)

MR. SUNWALT: Thank you so much for the opportunity to be here. I think that this will be an exciting panel. This is something that I'm very passionate about, is safety culture, because I think safety culture, when we have a culture that is oriented and directed toward safety, that drives the things that we do and ensures that we do it with safety.

And, so, I have titled this presentation "A Road Map to Safety Culture." And originally it was titled -- at 7:30 last night, it was titled "Establishing and Maintaining a Safety Culture."
And by 8:30 last night, I had changed the title of it to "A Road Map to Safety Culture."

And the reason I have changed it is because I don't think that you are ever there. It is a continuous process of striving to achieve a safety culture. So therefore, I think that we -- this is a road map, a number of stepping stones that you can follow to get you well on your way towards a safety culture.

On a number of occasions, the NTSB has recognized the lack of organizational culture of safety as a contributing factor of the accident. I pulled a couple of accident reports and scanned them in, and they are in all modes of transportation. This happen to be a highway accident. This is an aviation accident. And this is a transit rail accident, one that you are all familiar with, the WMATA accident at Fort Totten.

In the Fort Totten accident, the NTSB in part of the problem we will call a statement, said contributing to the accident was WMATA's lack of a
safety culture, and also there were five contributing factors. These are two of the five that we are looking at, and number four was ineffective safety oversight by the WMATA board of directors.

So, we cited the lack of a safety culture and the fact that board of directors, in our opinion, was not tracking the right kinds of things.

So, what is a safety culture? I mean, I think there are probably hundreds of definitions, and I don't think that there is a right one or a wrong one. This is one that I was still working on, somewhere between changing the title of the presentation at 7:30 and finishing at 8:30 last night, I sort of changed it around a little bit.

I will show you two versions of a definition and you can create your own definition. But just to sort of put us all on the same page or two, if you will, instead of having safety culture as being some elusive thing, this is the way that
I look at it.

Safety culture is a set of established attitudes, values, briefs, norms and practices where safety is revered, safety is revered, promoted and treated as an overriding priority. And it begins at the top of an organization, at the very top and it permeates throughout that organization. It has to start at the top.

And a month ago I went to a meeting hosted by the Nuclear Regulatory Commission, and it was on safety culture. And one of the definition that they had come up with in NRC -- and I modified this slightly, but basically the gist of what they say is, safety culture is the core values and behaviors resulting from a collective commitment by leaders and by individuals to emphasize safety over competing goals to ensure the protection of the people in the environment.

Of course, in the nuclear business, they are very concerned about, obviously, the
environment. So, that is why that is in there.

But the point is that safety is emphasized over competing values. What might competing values be in the transit rail business?

UNIDENTIFIED SPEAKER: Production and on time performance.

MR. SUNWALT: Yes, on time performance, production, financial concerns. Are we balancing safety in the same group or is safety just something else?

So I have come up with a list of characteristics of effective safety culture, and four of these items are actually in the report that the NTSB did for the WMATA accident, and those would be the last four: Informed culture, reporting, learning and just culture. Those are actually spelled out in our report of the WMATA accident. And those four are taken from Dr. Reason's book, specifically in his book, "Managing the Risks of Organizational Accidents."

But the first bullet point I added in
there last evening, because I think that we cannot overlook the importance of the senior management commitment. And I think if Jim Reason were here, he would be saying right now, yes, senior management commitment is key to establishing a safety culture.

So, let's take a look at each of these, beginning with senior management commitment. Safety culture is triggered at the top. And it is measured at the bottom. If you have got people up here saying that you want safety, but your people at this level here don't really get it, then you don't have a safety culture. And you can have people up here all day long saying they want safety, but if it doesn't work all the way through, you don't have it. Safety culture starts at the top of an organization and it permeates throughout.

This is right out of the NTSB's report of WMATA. And it says: Senior management demonstrates the commitment to safety and a
concern for hazards that are shared by employees at all levels within the organization. We have got to have that senior management commitment.

Let's talk about what informed culture means. Jim Reason says that in an informed culture, the organization collects and analyzes the right kind of data to keep it informed of the safety health of the organization. The right kind of data.

As Earl is going to say in just a little while, the right kind of data is correct. We did find in the WMATA accident they were collecting data, but the information that was making it to the board of directors and the safety committee, operations -- customer service, operations and safety committee, the information that was making it to the board of directors was dealing with elevator outages, crimes in metro parking lots and stations, improper door operations, and it also looked at things like -- it did look at fires and derailments.
But for the most part, the NTSB felt that the metrics that the board of directors were looking at was not the right metrics. They were looking at basically production safety and not process safety.

Did I say that backwards?

UNIDENTIFIED SPEAKER: You said it very well.

MR. SUNWALT: Okay. Thank you.

So you have to look at the right thing, don't measure the wrong thing, precisely. So an informed culture the organization creates a safety information system that collects, analyzes and disseminates information on instance as well as near misses, as well as proactive safety checks.

What are some examples of those kinds of things that you can use to keep your finger on the pulse of your organization? Well, for one thing safety audits, internal audits, external audits, confidential reporting, employee feedback.

And in the airline business we use a
program call flight operation or flight operational quality assurance, whereby the airlines download on a routine basis basically the information that would be on those crash recorders. In addition to having the black box crash reporters that the NTSB uses in solving an accident, the airlines have another data acquisition unit that can record at 250, 300 parameters.

And on a routine basis, airlines look at that data. But they are not looking at the individual's performance. They are looking at the performance of the system. If they find an anomaly, they are not interested in finding out that Robert Sunwalt had an unstabilized approach flying into Charlotte. What they want to do is an aggregate to say, my goodness, we have had seven unstabilized approaches going into Charlotte this month, what can we do about the system to correct the system?

It is not a punitive system. It is a
system whereby we can find out where the problems are before there's an accident occurring. And the Safety Board has recommended that approach coming out of the Chatsworth, California accident that happened in LA. There are a number of ways you can keep your finger on the pulse.

A reporting culture is one way that you can stay informed. In a reporting culture, employees are open, they are even encouraged to report safety problems, and they will do that. They will report to you information that you need to know what is going on in your organization if, if you provide them assurance that the information will be acted upon.

I was a line pilot for an airline for 24 years. There is nothing more frustrating than filling out a report to tell the problem -- to tell the company of a problem and then feel like nobody even read my report. But if the employees know that, you know what, we have a system, we want your information, we will listen to you, we
will evaluate what you are telling us, and if we feel that change needs to be made, we will. But on the other hand, if we for whatever reason can't make that change, we will still write you back and tell you why we are not going to change it.

But you close that feedback loop.

Employees need confidentiality. They need assurance that the confidentiality will be maintained or the data be identified. No one wants to fill out a report if they are going to have some notice on the bulletin board that says Robert Sunwalt screwed this up, and nobody wants to do that. He is going to report knowing that that information will be confidential.

And people need assurance that they will not be punished or ridiculed for reporting. In the airline business, many of the airlines have what is called a non-reprisal policy. When I want to run a Fortune 500 flight department between the airline and NSTB, I basically took the airlines non-reprisal policy. It is about a three or
four-paragraph statement. It is posted. It is signed by the chief executive officer, might be signed by somebody else, but it's signed by the CEO.

And the long and the short of it is that the company says, we will not use this reporting system to initiate disciplinary proceedings against an employee who discloses in good faith a hazard or an occurrence involving safety, which is the result of conduct that is inadvertent, unintentional or not deliberate. You tell us information, we are not going to then use it against you.

How do you keep your finger on the pulse of what is going on in your operation? Are you taking corrective measures? Do you have multiple data sources, not just one of those ones that I put up there earlier where I talked about audits and confidential reporting systems and quality assurance programs; not just one of those, but multiple sources of information.
You know, I flew airplanes for a long time. My family really felt that those engines on the airplane that I flew were very important. My family wanted those engines to operate properly. So in the cockpit of that airline, we didn't just have one instrument that say engines, good, or bad.

We had multiple sensors. We had engines -- N1, N2, EGT and fuel flow, fuel temperature, fuel quantity, oil temperature, oil property, oil pressure. We had multiple engine instruments to signal to us the safety health of those engines. And why? Because the engines were darn important to us.

So wouldn't you love to have sensors located strategically throughout your organization to signal to you the safety health of your organization? And, in fact, you do. Those sensors look like this.

What do you have, 1,000, 2,000, 5,000, 7,000 employees that are out there working in the
systems day-to-day. They know what works, they know what doesn't work. Who better can signal to you the safety health of your organization, if you simply open the door and provide them with a reporting culture?

Jackie, you wouldn't believe how hard it was to get a picture of a subway worker. And at 6:00 o'clock last night, all I was getting pictures of people that in the Subway Sandwich shop.

Another component that you need is a learning culture. And basically that means that the organization has to be able to learn and change from prior mistakes. If you are not learning from prior mistakes, you certainly are not on your way towards having a safety culture.

And finally you need a just culture. This is a term that is tossed around a lot. Basically a just culture means that employees realize they will be treated fairly. That not all errors or unsafe acts will be punished if the
error was unintentional.

   Somebody goes out and makes what I will call -- use the term loosely, but if somebody goes out and make an honest mistake, they are trying to do the right thing but they create an honest mistake, are you going to punish that employee if they come to you and say this is what happened, this is why it happened, I think if this was done differently, we wouldn't have gotten into this situation? Do you want to punish that person?

   If you punish that person, you will shut down a flow of information just like that. I remember going in to see a chief pilot one day. I wanted to tell him that we kept loading the wrong checklist into our airplane. There had been an error on this directive that came, and we had to change our checklist. And every time a mechanic would come out there, they would pull that one out and load the old one.

   So, I told this chief pilot that. He said, you know what your problem is, I'm thinking,
I said I didn't know I had a problem. He said your problem is you are thinking too much. I can guarantee you I never have gone back to that chief pilot to tell him anything. And I was a pretty conscientious employee. But can you shut down the flow of information just like that.

Now, that is not to say that if somebody recklessly goes out -- someone is reckless or deliberately doesn't follow a procedure, that is not to say if somebody does that, you are not going to take some sort of -- consider some sort of disciplinary action. You can't tolerate people that recklessly don't follow procedures. But for those who are making the honest mistakes, you understand that we need justice. That is the -- "just" is the root word of the word justice.

Jim Reason has written -- and I will show you the source for this in just a moment. Just Reason says that a just culture is an atmosphere of trust in which people are encouraged, even rewarded for providing safety
related information, but in which they are also a

clear line between acceptable and unacceptable.

A good document for learning more about

a just culture and probably will tell you more

about it than you want, but it is from the Flight

Safety Digest in March of 2005, they published

this article, "A Road Map to a Just Culture.

And in there, Jim Reason says -- he

emphasizes that a just culture is not a no blame

culture. A just culture is not where you give me

information and you "get out of jail free". Just

culture is where we are going to determine which

side of that line you happen to be on. The line

of the honest mistake and we are going to learn

from that, or the line of somebody that is

recklessly going out and disregarding procedures.

So, we have some characteristics of an

effective safety culture. You have to have the

safety management committee. You need an informed

culture, a reporting culture, learning culture and

just culture. So sort of to wrap it up, Jim
Reason would like to say, do you have a safety culture?

And he goes on to sort of slap us in the face and wake us up. He says it is worth pointing out that if you are convinced that your organization has a good safety culture, you are almost certainly mistaken. For it is the -- a safety culture is something that is striving for but rarely obtained, and it is the process that is more important than the product. It is the fact that we were going out constantly striving to do better, it is that chronic unease that wakes up at 3:00 o'clock in the morning and says, oh, my gosh, is this procedure that we just implemented, is it going to hurt somebody? It is that that keeps us on our toes.

So one way I look at it is you know you are on the right road towards that safety culture when the organization manages and values safety just as they manage and value other vital business functions.
You know, thinking about finances. All of these Fortune 500 companies they are interested in finance. And to show that they appoint a chief financial officer, and they have generally accepted accounting processes or GAAP that they followed. They have procedures, financial procedures, audits and controls. They have accountability they have a Sarbanes-Oxley statement that on a quarterly basis the CFO or the CEO have to sign to say that we swear that under the penalty of law that what we are reporting to you is correct and we have these processes and procedures in place that measures our finances. But we are saying that finances are very important.

Do we do the same things for safety? Is safety revered? Is it something that you put as much emphasis on as you do your finance, your on time performance, your reliability, or is safety just the guy that is down the hall down there I think it is the third door on the left? If that
is the way that your organization manages safety, I would suggest you are not on the right path to having a safety culture.

So, I really want to thank for your time. I think this is a fascinating discussion. Thank you very much.

(Applause.)

MR. FLANIGON: Thank you so much, Mr. Sunwalt.

What we are going to do is have each of the individuals make their presentation, and then we will have a roundtable discussion, where you can engage them and they can engage you. And I would hope that everyone on our committee is taking some notes, thinking about how this information might be helpful in meeting our tasks, because I think there is a lot -- there is going to be a lot to chew on here for us.

One of the things I was struck by that you mentioned, I think quoting Mr. Reason, that if you think you are there, you most likely not
there. And I recall that coming up at the public hearing. I don't know if it was Earl or one of the other folks at that public hearing saying, if you believe your own press, you are probably in trouble. And somebody else said, well, another way to say that is, if you are breathing your own exhaust --

(Laughter)

MR. FLANIGON: So, the whole idea is that there is -- you know, you are never quite there. And I think that is a lesson for us, we are having a very successful meeting, I think, but this is really a baby step and we have a lot more steps to go through before we get to the point where we can say we still have a long way to go but we are making progress.

So, with that, let me introduce next Mr. Tony Fazio, which is my DOT sibling at the Federal Aviation Administration. He has been there for 28 years, and he has a number of positions with the FAA. He is currently director
of accident investigation since 2009.

Over this past year has managed the merger of accident investigation with the office of data analysis to form a new office of accident investigation and prevention -- I'm sorry -- it is accident investigation and prevention. And the whole idea is to position the FAA to better meet its safety management responsibility.

His previous jobs included director of FAA's Europe, African and Middle East office in Brussels, Belgium. That sounds like quite a job. He holds a master's degree in public policy from the University of Maryland.

So, please join me in welcoming Tony Fazio.

(Applause)

MR. FAZIO: I always find it somewhat daunting when I have to follow a pilot. Even though I have 28 years in the FAA, I am not a pilot or an engineer. So I will tread lightly here.
When Mike first asked me to do this presentation, he asked me to talk about SMS. I asked my folks, give me your SMS presentation? So they put together a presentation and then I saw your resumes.

MR. FLANIGON: Put that up a little higher.

MR. FAZIO: Is that better? That is why you never want to ride with a pilot. Have you ever driven with a pilot, they always get lost?

(Laughter)

MR. FAZIO: I had to get those jokes.

So, anyway, I asked my folks to put together an SMS presentation. But I saw the composition of this panel or this advisory committee, I go, well, wait a minute, these guys can probably teach that course. So I'm not here to teach you about SMS. I think you are all safety professionals, you probably know the elements more so than I. I have only had 1 year in this job.
So what I am going to focus my presentation on is what we are doing in aviation to apply SMS principles on a day-to-day level. And I think we have some very good examples. Robert alluded to several of them, I'm going to kind of tie it all together, if I will.

So, when I heard that Robert was going to be on the panel and speaking about safety culture, I said, wow, that is a perfect segue to what I want to talk about, because everything I am going to talk about cannot happen unless you have that safety culture. I think you will hear it from all three of us, and I am sure those of you work in the field you cannot get your job done without that culture.

We can talk a good tune. We can put in place the policies and the procedures and the tools. But at the end of the day, they will just flap in the wind if there is nothing behind it. And vice versa, if you have a culture but you don't have the tools and mechanisms, you can't
achieve what we are trying to achieve.

Let me see if I can get this going here.

So why are we applying SMS now in aviation? Well, those of you who know SMS know that many of the principles have been around for years. There is nothing new about safety risk management, there is nothing new about policies and promotions, that sort of thing or safety assurance. We all do some form of safety assurance.

We put in place -- and SMS we are looking at a systematic approach, an integrated approach, and that's the difference. We decided we had to apply it to aviation because our industry has changed. Over the last 20 or 30 years our industry has changed. You may not see it inside the airplane, composites now rather than aluminum. Avionics have changed. We are going from a ground-based system to the satellite-based system.

So, the technologies are becoming more
and more difficult. We in aviation have obtained safety levels effectively while (inaudible). We have an accident there are (inaudible) random abates. Over the last couple of years now we are starting to see a plateau here. Effectively we have reached a point in our history to where it is hard to get better, so we have to apply new techniques.

Our business model is changing. I'm sure everyone in this room has flown Southwest or a regional carrier as part of coach. So, we have got to keep up with that. As a regulatory agency, that's very, very difficult. Maybe you are working in regulatory agencies. You know how difficult it is to change with the technologies.

And lastly we are seeing the demand in traffic post 9/11. It actually went down, but now we are starting to obtain those levels again. We are getting to the level -- we expect it to grow in the future. So, if we are going to maintain a safe system, we have got to put in place the
mechanisms to ensure we can do that.

So, I want to do this. These are the accident numbers we are looking at. If you can't see it, we basically have set benchmarks for ourselves that we will have no more than in this fiscal year 8.1 fatalities for 100 million passengers flown. When you translate that, this year we just had our first commercial accident last week, in fact, a UPS 747 in Dubai, two fatalities.

But those are the kinds of numbers we are looking at in aviation. Last year we had 52 of (inaudible) accidents. So we are in double digits now, single digits (inaudible). I want you to focus in 1996, because much of what I will talk about emanates from that period. That was probably one of the worse periods in U.S. civil aviation history. We had a number of very high profile accidents; TWA 800, ValuJet, you probably all heard of those. So that is what we are looking at in our sector.
So the industry itself decided we have to adopt SMS. So two things have happened very well, not recently but in the last few years. The UN organization for aviation is called the International Civil Aviation Organization. They have decreed that all service providers i.e., airlines, air navigation service providers, maintenance facilities manufacturers of airplanes, ultimately will have SMS programs in place.

So, that is kind of a mandate that we in the United States will be following and have begun following. And just 32, 34 days ago -- this is very important -- Congress passed a safety bill which requires us, the FAA, to implement or publish within 90 days a notice of proposed rule making that will require SMS for all 121 operators in the United States -- 121 are all commercial, nine seats and above.

So, we are in the process of frantically writing a regulation that will implement that in the United States. So you will see that coming.
So, I throw that out there as this is just not us talking to you as safety professionals but the Congress, the international community has recognized that SMS is the way we have to go.

So, again, I don't want to preach to the choir so much, but basically, as I tell everyone, there is really, really nothing new here. When I first took this job, people said, well, you know we are going to SMS. I couldn't understand it. What do you mean?

And the more I looked at it, well, we do -- we have policies for safety. We do have risk management. Safety assurance. We have a boatload of inspectors they are out there looking at aircraft every day. And safety promotion, I can show you literature left and right, we all have it. It is all hanging on the walls.

The difference of course, is what you do with it. And you Robert summed it up right. You have to have the culture, you have to go the next step.
So, what we would like to look at is a systematic approach. It is tying all of those elements together. So you don't have a department that does your PR work, another department that does oversight capacity, another department that is over here writing the speeches for the chairman or whoever it may be. It is all tied together.

It is not easy, I can tell you that. We are trying to do that in our agency. But one thing I have left out is there are no SMS requirements internationally for the regulator. There are what we call state safety programs. But we at the FAA have decided that we will adopt SMS in our oversight safety, so we are going to be an SMS organization.

The FAA is one if not the only regulatory agency in the United States or in the world that is an ISO 9000 organization. We achieved that about 4 or 5 years ago. So, we are now taking that to the next step, which is an SMS organization.
So again not knocking what Robert said, we have to go out there, track the hazards find the hazards, assess the risks and then take actions to address those. Okay. We all do bits and pieces of that, but we have to tie it together. That is the key here.

So, like I said, I don't want to dwell too much. I just wanted to kind lay the baseline for you, because there are some folks here are not familiar with SMS principles.

This little arrow, that is the key to the systematic approach. So, again tie it up in a nice bigger model here, you see the elements. And if I were to draw this on my own, I would have drawn another circle on the perimeter, that would be the culture. This is all enveloped, that white space would be your culture, because you can't do any of this stuff without that culture.

And I can't stress that enough, because as we are trying to adopt this into a regulatory agency, everybody has their own concept of what
SMS is, safety oversight is, we talked to you about that earlier. And, so, we really need to make that message loud and clear and crystal clear, because everybody will take what they want out of it, and that is really the culture piece and you have to model that.

I use an example. Mike and I are on a safety council. I don't think you were at the last session. One of the things we at the DOT are trying to work is on is the safety culture. And the example I use, some of you may know, those of us who are from the DOT know, the Secretary of Transportation issued a policy that as a DOT employee we cannot use cell phones in our car.

I made a point at the last safety council that should not have been necessary. We are all safety professionals. We should know that. But, yet, we don't act that way, do we, on our own? I notice you gave the exit announcement today. We are starting to do that, but we are safety professionals, we have to model that.
So to have our Secretary in this case tell us leads me to believe we still are not there yet, we have a ways to go. But that is the kind of message.

I will also share with you another story that I find fascinating. A former Associate Administrator for Safety at the FAA was visiting Dupont because Dupont is well known for their safety culture and their SMS. And they got out of the car, they parked in the parking lot and were crossing the street. They were literally accosted by a guard. The guard came up to them and said, sir, we are a safety organization here, we practice safety principles. You must cross at the crosswalk.

That is the message, that is the culture that takes it from the top all the way to the bottom. And that is what you got to do. That is what we all have to do as safety professionals, we have got to send that message.

As part of defining what SMS is, you
have to define what it is not. For those of you who have regulatory capabilities, this is very important because we are starting to see this. Canada is probably the foremost, governmental authority that has adopted SMS and suffered some of these consequences. It is not a new buzz word. As I said, it is safety, we are doing it. It really it is just a matter approach.

But the second one is one that I think we as regulators -- and you regulate here -- have to be reminded of. It is not a revocation or an advocation of your responsibilities. It is just the way you are going to fulfill that responsibility in the future.

We had inspectors, and Canada suffered this, where they delegated a little too much to the industry, and the industry was self-certifying. And they got a lot of criticisms for that. And so, that is something that we tell our folks, you are not -- change the way you are doing your business, but you still need to provide
oversight, you are the safety regulator. It is not outsourcing. You will hear some of that, too, while we are delegating more and more, that is not going to be the case.

And lastly, you need a separate safety department. You need your safety department to do that integrated approach.

So, again, that is all I really wanted to talk about on SMS, the concept, the principles.

What I now want to talk about is what we are doing and have been doing in aviation for a number of years, by the way. Again, that is problem following the first speaker, Robert has talked about it, but I will go into a little more depth.

Again, this is my pitch for the culture.

Again, we do a good job of looking at the past. I have some colleagues here from the NTSB, forensic approach, and looking at the accidents to try to learn from them. We have always done that. But we are now at the point in aviation we have got to
start looking forward. What are the issues that are going to get us before they turn into an incident and hopefully never a accident?

So the 3 areas that I'm going to talk about are commercial aviation safety team, we use acronyms, so I will refer to this as CAST; voluntary submitted information program, Robert talked about it, I will talk about it a little bit more; and lastly, something we are very, very excited about, which is our ASIAS program, which is the ability to now tie some of the things I'm going to talk about into a whole and predictable tool.

So if you recall, that chart that I showed you there was that big spike up in '96, where we had several accidents. Well, immediately after that, Vice President Gore formed an aviation commission. And that commission recommended that government industry get together and to begin looking at the causes of accident.

And what they recommended, which was
unprecedented at time, was a government industry partnership again. Again, we as regulators, we know how to regulate, but can we keep up with technologies, can we keep up with the way the operation are occurring? We hire folks from the industry, but they lose that capability very quickly, if you will.

So, the idea is to bring the best minds together, and that is what occurred here. The idea was all voluntary. What you find adopt voluntarily. You will see that the industry on their own have adopted many of these suggested remedies, all data driven.

Initially in '96 this was not known as SMS. It was safety oversight or the safety promotion, that sort of thing, but it wasn't known as SMS. But I draw this out, because this is effectively what SMS is.

The goals. Eighty percent reduction in the fatal accident rate. When we heard that, we were like, oh, my goodness, it is not possible.
But, yet, as I will show you, we came pretty darn close. And then we continued that well beyond 2007, which was the end date for that 80 percent reduction.

So, this is a makeup of all of the participants in CAST. And, so when I was preparing this, I was thinking, I imagine you have similar associations, unions obviously, you have NTSB (phonetic) but on the industry side, these are all of our participants: The manufacturers, trade associations, airports, engine manufacturers, flight safety foundation. We have a number of observers on the government side, DOD, FAA, NASA.

We do have a number of observers in Europe. Europe now has adopted ECAST, which is the European version of this. So, we are sharing the information that we are learning. So, again, this is a government-industry partnership.

The way it works is basically the teams get together or they did get together back them.
They looked at all accidents. They literally would scour through all the accident reports and find those causes of accidents, and then assign them to data analysis team.

The data analysis team would review that, rank the order of each of the casual factors and then assign an enhancement to these other two teams, who would then come up with safety enhancements. And those enhancements then would be looked at and then offered up to the industry as solutions to these problems.

So this graphically shows you what happens. Use the data, set your priority and then implement. And the beauty of this is now it has caught on internationally, so, you are seeing a worldwide reduction in the fatal accident rates data partly because of this, partly because of technologies. But at the end of the day, we are using the data to get to solutions.

So I mentioned the 80 percent reduction. We didn't get it. We got to 72 percent through
the CAST initiatives, we are getting an extra 4 percent from other initiatives outside of CAST regulatory capabilities. If we have no accidents for the next year, we will reach 80 percent in July of next year. So, that's an enormous, enormous achievement, if you will.

But if you look at -- there are various contributing factors to accidents. CFIT was controlled flight into terrain. We virtually eliminated that. That is basically advertently an aircraft will fly into terrain of some sort. We have virtually eliminated that by using collision avoidance equipment in the aircraft. It's radar equipment. As you see, we virtually got the risk out of the system.

Again, this is all through using data, going back looking at the significant factors of that and then collectively as a body with government and industry working together to implement those solutions.

At the time this information is dated
they said there were 72 safety enhancements that
were developed. And once these safety
enhancements are written, they are out there for
the community. So, now, what we are doing, we
have actually worked over the last few years with
China. China has one of safest -- they had until
last month, the safest accident record for the
last 5 years. They had no accidents for the last
5 years. They are adopting many of these safety
enhancements.

And the beauty is, in our industry,
anyway, aircraft are aircraft and for the most
part, operated fairly similarly, if they are not,
some of the enhancements address that. You can
apply these across the board without significant
changes. You don't have to re-create the wheel,
if you will, these guys figured it out, and put it
out there, and that is what we are finding is
happening in our community.

The second area I would like to talk
about -- and again, I'm doing this kind of
sequentially because I will tie it all up at the end here -- voluntarily safety programs. Robert alluded to FOQA (phonetic) which flight data recorder or quick access recorder, perimeters of the aircraft could measure up to 200, 300 kilometers (phonetic) of aircraft. What is the aircraft doing at every moment, it is significant information.

Airlines -- most airlines are now using these programs for their own use. ASAP, Aviation Safety Action Program. Robert mentioned that he as a pilot would write up a report and submit it. These are now very standardized programs used in aviation. In fact, the first two are protected, so you as a pilot, you as a mechanic, you as a flight attendant, write up a safety action program. You can submit that, you are effectively indemnified by the FAA. It is accepted by a review board that it is not malicious, intentional. It was error. Is it used as a learning opportunity.
You'll sit in front of the board. The board decides indeed this was a mistake, not intended. You are indemnified, because the point is we want that information. And I will show you some numbers at the end here of how many of these we are getting.

Voluntary disclosure reporting program. Very similar to the ASAP, except that applies to the company. A company may find, oh, my god, we were going something totally wrong, FAA never caught us. But we think we are in noncompliance with regulation. We are going to self-disclose.

The FAA will say, okay, fine, we will not issue a civil penalty on this, but you have to have a corrective action, and you have to do it within a certain time. If not, we can come after you.

So, again, these are all incentives to get that information flow that Robert talked about.

Just this last year, beginning
January 1, the FAA itself, our air traffic controllers now have adopted a similar program to ASAP called the ISAP. So controllers now can submit these reports and tell us, the FAA, I made a mistake here, I don't know why but this is what happened. So, now we can get that information, and what I will talk about towards the end here, we are tying all of this information together.

This last item is not, quote, an FAA program. And all of this these first four are information that are shared with us the, FAA, via third party, I will tell you why I say third party.

The last one is a program that has been in place for a number of years, LOSA, where the airlines themselves do check rides of their pilots and check their pilots with their own employees. Again, information that they can use to improve their operation, their safety operations. This information is not shared with us at the FAA.

It is ultimately shared within the
community, because one thing that is now occurring is all of these individuals that are involved in these programs get together on a fairly regular basis and share information. It is called an info share information.

So, you will get the community coming together and saying, you know, I experienced unstablized approaches in (inaudible). It might be an example of people fixing it, similar things, because seeing things you guys have seen this in from another airline. I saw that, too.

That could lead to an ASAP report to VDRP or amongst the community itself, it will decide, we have to look at it, let's give it to the CAST.

So I mentioned the first two. Now what we are doing, we are bringing all of the procedures of the CAST mechanism with the data from the voluntarily submitted information all together. And we are calling this the aviation safety information analysis sharing tool. We are
able to do this simply because computer power today is enormous, terabytes, terabytes you can collect. We all have data. We just don't know what to do with it.

Now we have the capability of bringing that data together. So we are writing programs that create common taxonomies. I think I was told there is probably 20 different ways to say 747, for example. There are different ways that you record it. Again, you have tools that can bring all this together, and when you see a 7-4, you know it is a 7-4.

It is our ability -- and normally when we show this, we will show (inaudible) but this is our attempt to try to begin predicting the future. Reading all of these data sources together so that we can see a problem before it occurs.

We had examples of where we used it -- I won't go into it today, because I don't want to stress -- this is a tool that your industry could probably use or the capabilities, because whether
you are Metro here in Washington, one of the Metro passengers; I hope you will think about this, or BART, I would assume that you are collecting similar types of data. Well, why not start sharing that if you don't.

So the ASIAS is all of the members who either -- I shouldn't say all members -- 32 airlines as of August 1, we are probably a little over that today, who are either providing the FOQA data or the flight information data or the ASAP data. So these are various airlines around the country that are participating. We are getting this information now into the massive database and able to -- so when Robert had an unstabilized approach, and he reported it to his management, that may have been one particular incident.

But if we get three or four other reports from other airlines or other pilots from his company, then you start seeing the bigger picture. You have got more data sources, more data points in which to make the same decisions.
ASIAS gives us that capability.

Now, I caveat this by saying, we, the FAA, do not get the information directly. You can imagine this is information that is very sensitive. Right? We are going to get as a separate report — pilots don’t want to be called upon, airlines are concerned about some operation data providing — so all of this information goes to a third party, the MITRE Corporation. And they process this information both on behalf of the airlines and as part of this ASIAS consortium.

So I talked about the data sources. So we can focus — I think there was — I talked about these. These are the volunteers with proprietary information.

Now what we can do with this massive communication capability is we can start tying in information that we get that the agency has, we have radar data, for example, as the (inaudible) which is surface at various airports now can give you more accurate information than some of the
FOQA data on position of the airport grounds. We can tie that in with publicly available information in TSP databases, for example, and then other government agencies who participate.

So, now we are able to collect all of this information, and you can literally fuse this data to paint a picture. And, so, our hope is and I know we are going to get here, is we are going to start looking at the vulnerabilities before they happen. So, for example, we talked about unstabilized approach, this is a common problem, it is coming down over the years, but it is still out there. This is when a pilot comes in, he's not at the right speeds, high attitude, that sort of thing.

So, can we predict something on that? Well, we are not sure, but we know what we think is stabilized approach so we can draw boundaries. And then we can say, okay, here are the bands. If an aircraft is out of band, that might be a vulnerability. It may not be unsafe. It is just
different. We need to look at it. And, so, that

is the kind of thing.

We are really at the infancy stages, so
I will not show you too many examples of that.
But that is the start of the things we are
starting to look at, what is normal and what is
outside of the norm. Do we have to study it as
collectively as an industry?

So here are some of the data sources.
Seven point two million operations of the flight
data. This is as of August 1, I believe. This is
the type of data we now have available to us as a
consortium. These ASAP reports, these pilot
reports is 75,000, the ATSAP report for air
traffic was 14,000. I think that is much, much
higher now. In the last couple of months we
really generated a lot (inaudible) data.

And, so, the idea, this is the kind of
information that is out there, and I suspect for
your industry, this information exists also. You
just got to bring it together.
So what do we do with it? We do a number of things. We do directed studies, as I mentioned the info share, if somebody highlights a problem, and I say we really should look at this issue. They will bring it back to the ASIAS executive board, which is cochaired by the FAA and the industry representative from Continental right now, and they will decide collectively should we look at this, and they will do a study.

They will look at known risks. The one element of SMS that is absolutely critical is we've done risk management and we put in place safety enhancements, but then you recheck to see if they have been effective. We have not had the capability of doing this. So, if we think we have corrected that unstabilized approach at a particular airport, we can go back now and see did that safety enhancement actually solve the problem? So it is that continuous loop, if you will, that is necessary with SMS.

Benchmarking is one that is particular
valuable to the airlines themselves. They can
assess themselves. They know what their data
says. We don't know because all of this
information that comes in should be qualified it
is all to be identified. So, we don't know from
what airline, that particular operation is coming
from. So it is all identified. But the airline
itself knows what its information is. And they
are now willing to share or I should say the other
way around -- MITRE Corporation develop a
benchmark saying this is what normal looks like.

The airline can say, well, I'm below
that, I think I'm doing well, or I'm above this, I
need to see why. So, it is an ability to do
self-assessment, self-correction. I believe I am
down to one.

So, SMS for us is going from looking at
what happened to trying to predict what is going
to happen. So we are going from a forensic to a
prognostic. We believe safety risk management is
the way to do that. We in the agency prefer you
to do that when we are making decisions. Our engineers are very used to that sort of thing, but our pilots, our mechanics and our flight operations organization are not. So we are going to try to come up with standardized ways of doing that.

These information tools that I spoke of like ASIAS we risk mitigation. So, hopefully, I was able to present some best practice that we are using in aviation that you are able to apply. So thank you.

(Applause.)

MR. FLANIGON: Thank you, Tony.

You know, looking at information about what we call near misses or errors whatever, I was doing some reading the other night, I think it was some of the SMS material, and something struck me as I was reading it that in being reactive, you know, looking at accident investigations and learning from them that's certainly necessary thing to do.
But it is a very expensive lesson. And that if you can get at incident before the accident and learn from them, it is really a free education as opposed to a very expensive education. And I think that is where we really want to go.

Next up before we have our group discussion is Mr. Earl Carnes. He is the senior adviser for high reliability at the U.S. Department of Energy, and he advises senior management and contractors on efforts to improve safety and performance in all areas of DOE operations.

He serves as liaison with the Institute of Nuclear Power Operations, facilitates exchanges of operating experience, effective management practices, and so forth. He appeared as an expert on high reliability organizations at the NSTB hearing that we talked about.

His prior DOE roles have included technical assistant to the director of nuclear
safety, principal nuclear safety evaluator for
emergency management, and policy specialist,
looking at safety management systems. He's
written the DOE human performance handbook and a
number of other publications. And he also worked
in the nuclear power industry before that.

Earl informs me also that he is no
relation to the hurricane that tried to below
through the East Coast a week or so ago. Actually
I think we have to thank for all of the good
weather. Maybe you do want to claim kinship
please welcome Mr. Carnes.

(Applause.)

MR. CARNES: Thank you all. I noticed
some of you turned your heads one way, so I will
shift over here so the others, your neck can rest
a little bit. Personally I need it, since I have
been flying a lot, like most of us, thanks to my
friends. So, it is a pleasure to be here with
you. How is the volume? Is it satisfactory?
Okay. Thank you.
It is like going to church, isn't it, Robert?

I have had the pleasure of knowing this gentleman for a number of years and because a number of us in the federal government have regulatory responsibilities, investigative responsibilities and et cetera, I would like for things to work this way. We have found out that a lot of us actively read, research and study to try the improve to execution of our governmental responsibilities.

We have started calling one another, I guess, 3 or 4 years ago, I think, something like that we came together informally and formed what we called the federal high reliability roundtable. We hope to expand and gain a tremendous amount of value getting together periodically. We spend a day discussing the scientific literature that we have been reading? How does it inform our thinking? What are the experiences that we have been having? What are the challenges that we
This has been going on for about 3 or 4 years and I think that it is a very healthy thing now one brain or one organization no one agency really is smart enough to know it all anymore. I think you gave an excellent example of the collaborative nature of regulation, voluntary action, the activity influence, and all of that in a way that frames what I want to present to you, very briefly here that I have entitled "Highly Reliable Performance."

I want to emphasize what Robert touched upon, that the core word is "performance." If we all have a mission to perform, whether it's aviation, rail transit, in my other life, the generation of electricity for nuclear power, science and technology in DOE, whatever, if we don't perform that mission, we are not going to stay in the business. If we don't do it safely, we are not going to stay in business and we will either harm someone or harm the environment.
So, it is the idea of performance.

Number one, I want to emphasize to you.

Number two, I want to emphasize an argument that I continually make, and that is, frankly, I would rather run our organizations based on research then simply our opinion on how we did business before individually.

Let me put it to you like this. Before I came to DOE, I was a management consultant working with troubled nuclear power plant and start-up plants. One of the last jobs I had before I joined the government was working in a plant in Texas. The executive assistant to the vice president was a lifelong resident of the state of Texas and she had a big sign over her desk, as you approached you could see it. It said, "Just don't tell us how you did it in New York," apologies to any you who might be from the wonderful state of New York.

There are many ways of looking at this but I want to give you one frame of reference.
And that is the third point. When we speak in terms of high reliability I look at my colleagues in the Department of Energy and other places. And I try to make it a point that this is a framework, a way of thinking informed by years of research.

And you may recall, some of you who studied this, the Peter Drucker made a living primarily from going into major organizations and asking what is your model of management. Frankly, most of the people who are in charge of our organizations, executive management levels, are there because they are very good scientists, good engineers, good attorneys but they have never been trained in these things.

We need a way up as our friend Carl (inaudible) the University of Michigan used to say of making sense of what is going on in our organizations. Both of these gentlemen talked about the many ways that we use to make sense.

I want to argue that we need a framework through which we can interpret what the data
means. That is the context of these two slides, if they will work.

A brief history. I lived part of my life in the academic world, part of it in the practical world, but I think that understanding history and the evolution of thought is important. So I take you back, many of you know these things, to the industrial revolution, and where we started looking at safety as Robert would say. How did we start looking at safety? Primarily from safety of the people who worked in the facilities. And before we started getting more knowledgeable, more informed, you know that this is the way we looked at things.

If somebody got hurt it was probably because it was their fault. Okay? Well, we know that is not true. We do know that as human beings there are certain things that we are very good at certain things we are not. For example, as someone talked about, talking on the telephone and driving on the beltway is not something we are
particularly good at doing, our attention is divided. There are psychologically reasons that are valid.

We need to be aware of those. We need to use those in our analysis and use them in our thinking is not always just our thought, okay, as if we intentionally did those kind of things. So, that is the old way of thinking. Okay. We have already talked about all of these things.

Today we are in a very complex world. As Tony was saying, the technology is changing, the organizations are changing. Old organizations are buying one another up, people are moving in and out. Technology is wonderful, but it also makes thing more complex because we have more data. Systems are more highly interrelated. So that the failure in one component can affect something over here that we never really thought of. Today we live in a context of increasing complexity. Both of the gentlemen and Mike have talked about the importance of understanding the
systems. Okay?

Now, also let me say that it is even more complicated, because I have a lot of good friends who are great systems engineers. They do good work but they just want you to go away and let them do their analysis. We have this messy thing involved, it's called people. People just don't behave according to the engineering equations.

So, it is not just complex systems, it is complex sociotechnical systems. The interaction of individuals, groups, social organizations, stakeholders, customers and regulators gets more and more complex. We have to have more or richer ways of thinking about how we manage our organizations.

Most of you are familiar with this but I want to emphasize it as Robert mentioned, two different models -- not the only models -- but two primary models that start the confusion, as Robert mentioned, the personal accident model and the
organizational accident model.

Many of you remember a few years ago I think it was Robert, it was the worse refinery accident that we had in the United States, I believe 14 fatalities and 40-some odd injuries. Our colleagues at the U.S. Chemical Safety Board investigated it and one of the recommendations were to have a review done by former Secretary Baker and his team. One of the key findings that they wanted to remind of us is that the presence of an effective personal safety management system does not ensure the presence of an effective process safety management system.

Worker safety is essential and most of the organizations in the world, when they speak about safety, speak about the safety of workers. That it is good that they do so, and it is essential. It is necessary but it is not sufficient.

Unfortunately, some big organizations, and we are seeing that play out today in the Gulf,
for example, that they do not fully recognize the
difference in the systems model and a personal
model, and that is where they start to go awry,
first of all.

So, the emerging paradigm. Robert spoke
about the whole idea of error, and the easiest
thing to do when something goes wrong is to point
to the people who were there at the scene and
blame it on human error again, Jim brought to the
attention to understand that error is not a cause;
error is a symptom.

Let's look at this paradigm. In the
traditional perspective of where we are going is
that, of course, things go right because my good
friends the engineers, of course, are so brilliant
that they designed these systems that will work
perfectly well, except for those nasty people
called humans.

So, everything will go right because the
systems are so well designed and maintained,
designers can foresee everything, procedures are
always correct, right? We know -- any of you use procedures by the way? Okay. If you do, you know those fallacies. I personally have been a user of procedures, you have been a user of procedures, and people behavior as they are taught and expected to.

This idea of work as imagined versus work as it is done is one of the most important phrases, and I would recommend to your attention as you reflect upon your responsibilities because the two are not the same. Senior management has a view of the world, okay, that is based on paper. The people that have actually do the jobs have a view of the world that is based upon confronting equipment and confronting uncertain and less desirable situations than the paper condition.

The new perspective, the emerging perspective is that things go right because people learn to overcome design flaws and glitches, learn to adjust their performance to meet the demands. They interpret and apply procedures to match the
conditions. They detect and correct error, which is key to where Robert was going in one of his slides. Okay.

And so the difference is that the old or traditional perspective is that people are a threat, and performance variability must be eliminated. Now, personally I like to say that is a formula for insanity. Okay. You tried the drive out all error and all variability and you go either bankrupt or insane or possibly both.

The emerging perspective is that people are the key to make model technological systems function. And Erik Hollnagel is the lead on this work. It is very important to understand those distinctions and ask, as (inaudible) would say, what is your organizational model? What is your model that management will follow? What are the assumptions that underlie those models. Okay.

So this works during (inaudible) the Three Mile Island, what is now referred as high reliability organizations or shorthand high
reliability. It began after the accident at Three Mile Island. A lot of research is going on and our friend Karlene Roberts, who is also a witness for Robert, she is a professor at the Haas school UC Berkeley and others at Berkeley who are joined by Karl Weick and Kathy Sutherland from Michigan and others. I'm sure I have a witness here.

But starting off looking at the FAA air traffic control system is a very highly reliable organization. Yet looking at the USS Carl Vinson, the aircraft carrier, looking at the Diablo Canyon Nuclear Power Plant -- that is not the Diablo Canyon there, that is Three Mile Island, for those of you who are geeks like I am -- and, of course, looking at submarines, and now recently, particularly since the 1990s, starting to look at medical.

So, here is the point. We started off looking at those kinds of things, nuclear power, submarines and esoteric things and complicated things like air traffic control, but how does this
apply to other things? This is where the research -- this is an example of where the research has been -- again, I want to point to health care.

I have the honor of being able to work with the joint commission for healthcare accreditation and healthcare (inaudible) system throughout the United States. They have adopted the HR model, again, as a frame of reference, a way of thinking conceptualizing this system, the sociologic -- it is important to say socio technical systems model, thinking about how to do healthcare. Personally I think that is very important, as I am not as young as I used to be.

Manufacturing, the military, offshore platforms, police forces, civil aviation enforcement, nuclear power plant warfares, submarines, railroad operations, wildland firefighting. We have colleagues that work in our HR roundtable from the forestry department, wildland firefighting. Electrical transmission,
distribution, (inaudible) date study in California, school reform, particularly in the UK.

So, the point is the principles and the concepts we find to have researched have very broad applications. The specific representation, specific applications depend upon the work done there, but it has been found to have a very broad application.

So with that -- so where do we get to performance? Here I give you the reason I use nuclear power in addition to the fact it is where I have lived for many years. We have 30 years of data on how to use these approaches that we call the rubric of HR or high reliability.

Let me direct your attention here. This blue line, called the reactor trips and scram, this is when the reactor shuts down. When the reactor shuts down, you do not want it to shut down, that is not a good thing, because that tells you something isn't going quite awry in your systems. That is not a good thing.
Also, by the way, if you shut down for a day, it will cost you about $2 million. So, that is not a good thing. In addition it stresses your system. You don't like that when your system is like this.

This thing right here, the green line is called a significant event. Now, you want over time is 85. You see what happens, trips and scram, it is going down to about .5 per year industrywide, okay. Right down here you could see what is defined as a significant event in the regulatory reporting criteria by NRC, you see it is almost to zero.

Now, the good stuff, first of all the capacity factor. If a plant runs the maximum it can run, 24 hours a day, 7 days a week, 365 days a year, that is 100, 100 percent capacity. Usually when this kind of work that we are talking about a high level of (inaudible) sun, you know, it is really getting started around about 1985. We were running right around here, which is, what, a
little less than 60 percent. Right.

You will see today that the average capacity factor is wide in the last figure I think we were probably right around 93 percent. You get a lot more production out of your equipment when you are running like that. About 30 percent (inaudible). The cost for kilowatt hours is consistently increasing.

The point is the performance of your operation has improved and the safety of your operation has improved by doing the same things. That is where these concepts tie together to say if you really want an excellent organization, a high performing organization, these concepts are what you use to get safety and improvement which is what we want.

The principles of high reliability are organizing as articulated by Karl Weick. Kathy Sutherland and other people have articulated it differently. (Inaudible). These gentlemen have both talked about these two things.
One of the basic concepts, is anticipating becoming aware of the unexpected because clearly engineers can engineer and designers can design for the things that we can expect. That is not what gets us into trouble it is the things we can't expect. So one of the hallmarks of a highly reliable organization or what seems to be highly reliable is what we preoccupation with failure. Always say what can fail, how could it fail? How could we be wrong? What might we be assuming would be incorrect? What could get us into trouble today?

The attitude and the way of thinking permeates the organization from the chief executive office, the board of directors, to the person who is working directly on the floor. We have ways of facilitating that kind of culture with those kind of techniques.

Reluctance to simplify? We have already addressed that because we know that our operations are no longer simple. We have to help people
develop complex cognitive models. This is one of the reasons I emphasize models so much is to understand what is happening in the whole system not just in your area but what might your actions do to trigger something undesirable over here. How is work in another area perhaps affecting the work you are doing today? That is a big thing, and sensitivity to operations at all levels, okay.

Robert mentioned CFOs and for example, in the commercial legal power industry, everyone in the whole organization is trained. Professionally developed on these concepts from, the board of directors there is an institute, a center for board of director education through my old organization who powers operations through Georgia Tech. For CFOs, HR directors and nontechnical directors, there is a similar center that is gone through MIT, okay. Then for line management everyone from first line leaders, the first line supervisors to CEO, there incidentally are professional development, all giving them
these same concepts. Developing a similar model, okay, is what this is all about.

Then for the utilities themselves, there is training for every individual in the organization. Okay. For example, one of the things you do in aviation is the course of communication, the feedback and using a sort of communication protocols. So, you know, I can call one of these organizations the person who picks up the phone before you exchange the information back and forth, is going to use the alphanumeric communication protocol.

The three-part communication, I say something to Robert, Robert will say something back to me, I acknowledge my understanding, those things are simple but powerful, okay everyone does that.

Then something goes wrong, contain it. Emergency management and emergency preparedness is probably parallel but the commitment to resilience, being able to respond to the
unexpected and being drilled and drilled to be able to prepare ourselves, and finally have the efforts of expertise. What does that mean?

Let's go back to the main example. That means on the carrier when the ship is operational, the planes are coming in and going out, the admiral is not in charge. You know what I mean, the admiral is always in charge, but the admiral does not get in the way of the people doing the jobs. It is those young 19- to 21-year-old people who are on the deck, supervised by the chiefs, who are running the show. That is their job. They are the experts. Okay.

So understanding where your areas of expertise lie, who should be doing what job when, that is really the exercise, the orchestration that the chief executives need to understand, first the locust of expertise. Okay.

So now we have talked about in terms of the safety management system. Let me emphasize that this whole idea of high reliability cannot
succeed unless you have a robust safety management system. Again, we are going into this whole integration of safety plus performance, unifying them together.

So, this is from a couple of other comments Wrethall and Woods. This is one of his classical models, but also built into this is this thing of understanding, as Drucker would say, part of your assumptions that go into your model. You know, asking the question, well, do I have a basic model for my safety management system, is that person centered model, do I have complex model, do I have resilience model? One of the assumptions that feed into the various components of the model. The whole thing on measurement here, okay, and how you get into that.

So, again, I just -- I give you that, again, to emphasize that it is having the robust model because of understanding the assumptions that underline the model and articulating those, so you can know why it is you think the way that
you do. That is the goal.

Then finally, these are what I would suggest for your reflection are basic considerations basic ingredients for high reliability. That is, of course, first adopt and adaptive systems perspective, that work is never the same as you imagine on paper. We have to define the acceptable bounds of difference. Okay. We have to understand what acceptable variability is. We have to empower the people in different conditions.

For example, you want people to act differently in an emergency than they do in routine operations. I will give you a good example. You know, when it comes to someone who is seriously injured or there is a very volatile event like fire, what is more important, keeping the secured door closed which is there to protect vital documents, or getting people out of that area? Okay. That is always an issue.

We want the prevailing wisdom to be
that, first of all, we protect human life. That takes priority over security of documents. We can handle that issue when the draw is opened. But those are decisions we have to make all of the time.

Using risk analysis to inform business decisions. Risk-informed decision-making, again, is a set of skills that we have to help people learn, and in learning and then embed into the processes of the organization, so that the safety priorities are always considered in any decision-making, particularly when it comes to financial decisions, okay.

Strategically invest in ongoing training. So many people think, well, we trained the person to do the job, they should do it correctly. Steel deteriorates, technology changes, things that Tony talked about. That had to always be reinforced, refreshed because of the changes that we talked about; making sure that we invest in our people because people actually solve
the problems. The technology is simply an enabler
to the different approach.

   Emphasizing an important analysis and
change in management. Performance improvement
analysis reporting has to become a core
competency. It has to become part of everyone's
job. Everyone needs to understand that they are a
change agent, a reporting agent, an analyst and
participate in that overall system -- these
gentlemen have already said that -- seek to better
understand work as done versus work that is as
imagined. And the only way you can do that is by
getting in there and watching work being done.

   If management is not living out in the
organization and walking down the space as we used
to say it, you know, and getting there and
understanding, then management is not doing its
job. Management observation, employee
observation, all of these multiple level
observations are part of the daily intelligence
system.
Balance expert and standard-based work. Everything cannot be reduced to a linear paper base procedure, but there are many different types of cognitive enhancements that point to this. We need to think of greater variety of that, how do we support people's cognitive processes and also understand that you can never, ever substitute for the true expert, but also being able to discriminate who is an expert, who is not an expert. That is a complicated equation, but it is essential.

Finally, to engage everyone. As Robert said, you have thousands of eyes out there. Let me give you an example to close with. In a good performing nuclear power plant today -- well, along time ago, it was fewer reports, better. You know, that was like 20 years ago.

Now we understand that a good performing nuclear power plant in the United States, the employee themselves are generating anywhere from 9 to 11,000 items per year in the formal
corporate-wide, plant-wide system. All of those are analyzed and treated throughout the system.

If you are falling below that is an indicator that you have a concern. Okay. So it is that kind of collective engagement.

That is what I wanted to share with you. Thank you very much for the opportunity.

(Applause.)

MR. FLANIGON: Thank you very much.

When I spoke with Earl about doing this presentation, I remember one slide that shows the safety performance, the operational performance, the capacity, the problem cycles. I said, well, I would sure like you to include that, because I think it fits with that concept that I mentioned at some point earlier that good safety management is good management. There is really a link.

And from my reading, I'm coming to realize that is all part of the fourth pillar of safety management system and safety promotion. That if we can -- show how there is a payoff, that
it can lead to that increased volume and higher
level from the organization.

So now we have got -- these expert folks
who have presented this information, and they are
available to us as the committee to ask some
questions and have some conversations and help
inform us and guide us on our task at hand.

Ms. McCombe.

MS. McCOMBE: I have a question for
Anthony.

You talked about the safety management
system at FAA and now you are moving to the
industry, to the airlines, so that they
incorporate safety management systems. So, are
you thinking that the agency -- not the agencies,
but the airlines will have the exact same
processes as you? How are you complementing that?

MR. FAZIO: I have to be careful about
being in -- but effectively the way we are going
to approach it.

MR. FLANIGON: Move a little closer --
hold it a little closer to your mouth.

MR. FAZIO: Can you hear me now?

So where we are going to approach it is performance based. So it is basically a lot of guidance out there. You see guidance everywhere. The aviation sector, like we spoke of, (inaudible) a civil has put together a number of documents. We had some orders internally. They all say the same thing, so the approach in rule making is going to be a must have safety promotion, you must have safety.

Safety assurance. You have to show us that you are doing some type of safety assurance.

Risk management. You are going to have to have -- track your hazards and then appropriately assess them.

So, the way we are going to approach it, it will be a rule that basically performance base for SMS, and then for each sector, the different parts -- newer parts -- will have regulations for each sector of the industry. Then we will adopt
that sector to meet that umbrella part of the -- I hope I answered your question.

MS. McCOMBE: Yes, you did.

So the FAA drove it initially, drove the SMS and created a great system. You have taken it down to the airline level, slightly different but it will be performance based?

MR. FAZIO: Basically. Again as I said, this has been going on for a number of years in a community of experts. They know what they want, so what we did not want to do -- and this is something you have to consider in adopting -- is many companies are (inaudible) ISO, they have quality management systems. They have safety assurance programs. They have all of this in place.

So, some of the pushback we are getting, in fact, is companies saying we don't want to reinvent the wheel, so that is why we are going with performance base. So long as you can show that you meet these elements, four pillars and the
sub-elements of each of those pillars, I believe you have met compliance with the proposed rule.

Now, the question we have to grapple with is how to enforce that. These are issues that we are debating now. For example, the FAA is going to have to assure that you are doing that, because we are the regulator. Why couldn't you have a third party, use a standard, for example? Unlike quality management or an ISO, if you meet the standards, you are assumed as qualified. Those are some of the issues that we are grappling with now. We have to have a debate. It will be a pretty big response.

MS. McCOMBE: On the inspection side, how many inspections do you do a year per airline?

MR. FAZIO: Oh, my gosh. I don't have numbers exactly, but we have 4,800, I believe, inspectors.

MS. McCOMBE: 4,800 inspectors?

MR. FAZIO: Across the country. They do everything with the airlines themselves, the
operations capabilities to prepare assignments. They have inspectors that (inaudible) manufacturers and the world, that sort of thing parts for manufacturers. It sounds like a lot, but it really isn't.

A lot of what they are doing now they are going to a risk base experience also. One of the things we adopted years ago (inaudible). Air transportation oversight system, which is was more risk based, so put your resources where the problems are.

I don't want to use names, but if airline XYZ you have a great safety record, maybe you don't need as much oversight as Z over here, who has shown some excess in incidents. So, that is kind of what SMS will take you over time. It will focus your resources on the risks. It is not easy to do.

MR. FLANIGON: Len.

MR. HARDY: I have a question for Tony. Kind of following up on the discussion you were
just having, and that is you talked about
performance-based evaluations, right? And you
talked about benchmarking. When you talked about
benchmarking, you talk about going through a third
party And basically drawing in from the whole
aviation industry.

Now when you talk about assessing
individual carriers, when you talk about
performance base, do you anticipate that you will
come up with benchmarks that you will hold the
industry accountable to? How would you measure
performance base if you don't come you with some
sort of a benchmark?

And is that in the works for you? Do
you think that you will -- as work through this,
that you will come up with benchmarking and that
eventually you will look at carriers and base --
assess their safety record, if you will, on the
benchmarks and whether they meet certain
benchmarks or not, and identify those that are not
meeting the benchmarks and basically, you know,
that's where, perhaps some enforcement when you come in?

MR. FAZIO: So, first and foremost, we are regulatory agency. We have regulations in place to enforce those regulations. So, that is the bottom line, if you will. So, the systems are going to be put in place to make sure that the regulations are being applied.

The idea of benchmarks that I referred to earlier are more for the industry to do a self-assessment of itself. I think I know where you are going. Part of what we are grappling with in the aviation section is part of that amass is an acceptable level of safety. And one of things that the international community we are all very (inaudible) aware of these, we in the United States have one level of safety, it may not be the same as, say, China or parts of Africa, so we don't want an acceptable level of safety that is applied equally across the world. So, in that regard, that has created a lot of concern in that
As far as benchmarking, I think as we evolve our systems, our oversight systems, there will probably be some type of benchmarking. I cannot tell you exactly what they are going to look like. I think we have to do that. I mean, a certain number of reports, for example, might be acceptable versus some that not might be.

MR. FLANIGON: Tom.

MR. PRENDERGAST: Tony, in your third party system where you try to guarantee anonymity so that you are providing for a free flow of information, do you have any protections against or limitations on other third parties who may, for litigation purposes, want to access that data for individuals and lawsuits and things of that nature?

MR. FAZIO: Excellent question. In fact, that is the dilemma we find ourselves in today. So when I spoke of protections, if you are providing confidential submitted information under
Part 193, which is a regulation that protects ASAP reports and the FOQA reports, you are protected from FAA enforcement. Unfortunately, you may not be protected from civil law. So, that is something, actually, the community is very concerned about.

We -- in our reorganization bill that is pending for 3 years now, the community has come together and asked Congress to provide some type of protection for litigants or against litigants, and I have seen draft language that would attempt to do that. Unfortunately, our reorganization has not passed, and is not likely to pass this year, so we don't know where that is going to go. But that continues to be a concern, if you talk to flight safety foundation, do you want to say some of this, too, that is a perpetual concern for the industry.

MR. PRENDERGAST: The reason I raise it, I mean, a number of people here would share it, is that I don't have a feel for the frequency of what
kind of litigation magnitude you see in the aviation industry, but on a local transit level it is significant. I mean, it is -- there are ambulance chasers that put up their signs everywhere.

And it is something that, you know, you never want to have to be in the way of getting the data, so eventually we will have to cope with it, but it is just -- with what is the best way to cope with it, because we don't want to say we don't want to participate in the system just because of that exposure.

MR. SUNWALT: I'm not attorney, so this is not legal advice, but the attorneys that I hear speaking about this very issue, point out that if these programs are considered best practices and then you don't have them, then you are probably opening yourself up for more damages because you didn't employment them to prevent the accident in the first place.

So that is sort of the thinking that I'm
hearing in the aviation community. And if you
don't have any of the problems then you are not --
then you are not held to that standard.

MR. PRENDERGAST: I totally agree. I
mean, the day of the general counsel telling me
they don't want information because they don't
have to defend against it, you generally fire
those general counsel.

MR. FLANIGON: Just from the standpoint
of the task at hand, in looking at these elements
of safety planning systems and what might work in
the rail transit industry, I think we are being
tasked with looking also at what might
challenge -- what challenges there might be and
what methods might we look at to overcome those
challenges. So, those are certainly thoughts to
kind of work into the equations as we do our work.

Other questions? Rick.

MR. KRISAK: I reading the reference
material you gave us on the FAA SMS system, there
was some reference in there to the involvement of
the states, individual states. What would involvement did those individual states have in the FAA SMS?

MR. FAZIO: So, the document you received was, I believe, a document put out by the airports organization. So that wasn't on like -- transit systems are involved in overseeing by states or by authorities. So, I don't work in that area, I'm on the safety side of the house. So I suspect if, you know, the state or the local municipality owns that airport, there is going to have to be a linkage back to -- they have responsibilities, they are operating that airport, they are going to -- in fact, I didn't mention it when I spoke of the rule making for the airlines, the airports organization also is going to be putting out SMS.

So my suspicion is it ties back to the, as the state is the operator -- I think we are in Maryland, BWI, the State of Maryland they have responsibilities, but they will have to be the
MR. KRISAK: The reason I bring that up is because, you know, we seem to be moving towards the model where we want state safety oversight to remain in place as an entity, a part of this increased regulation, but with an enhanced FTA role.

And my question, I guess, would be, if you guys had that structure, if you had to work within that structure where the major, you know, leadership role and oversight role were the states and not through a centralized FAA, how would you envision being able to roll out a program like you have?

MR. FAZIO: Well, you know, I would see -- they have to see us to their advantage. While we are talking safety, they are enormous (inaudible) to adopting the system. It is important (inaudible) to be focused on the safety side, you save money by being a safe organization. So, again, the airport side of the house, we can
mandate them because have federal redemption.

So, I would just sell the point that we are all care about safety. We care about doing it economically to save resources, because again, you also will hear a lot about in terms (inaudible). Safety is just one element. You have environmental management systems, you have occupational health safety system or systems, so there -- it is all good business practice, if you will. So I would sell it in that regard.

MR. KRISAK: And I guess I bring that up more as a concern to the group than to the FAA, but, you know, our model that we are talking about is a significantly different structural organization from what the FAA is doing. And I think we need to figure out how we are going to grapple with that, because we are empowering the states to a much higher degree than, say, the FAA does. We are more than an airport owner. We the operator. We are like the airline in your model.

MR. FLANIGON: Dave.
MR. GENOVA: I think it's interesting to observe that this is performance-based requirements, and I would just make an assumption, I don't know much about the aviation regulations, but I assume you have a whole bunch of prescriptive requirements about aircraft standards, systems standards, maintenance requirements, inspections.

And, so, is this the first time FAA is looking at putting in performance-based requirements in addition to all of the very prescriptive requirements that you have?

MR. FAZIO: No, it is not the first. But you are right, we have a lot of prescriptive regulations. But honestly, (inaudible) we are (inaudible) 7 years, and we are going more and more towards performance-based regulation. It is probably the best way to go as far as assuring what you want to accomplish that you are going to accomplish.

The dilemma, of course, comes in in
enforcement and interpretation. And, so, because of that, what you have to do as a regulator is write very good guidance material both for regulative part and for new inspectors, because, you know, it is all interpretation. But you can write the standard in such a way that, you know -- again, SMS, I don't think will be that difficult.

There are concerns and I have expressed them to our inspectors. They have to adhere to the guidance because we are often, as a government entity, accused of heavy hands. We will get individuals. So we talked about best practices.

We also had bad practices. We had inspectors that want to go out and enforce all the time, write the ticket anyway. And that is not conducive to this just culture. So it takes cultural change not only regulating the community but also the regulator.

MR. GENOVA: Just a follow-up comment -- actually this is on the HRO. And I made an observation when you had -- under some of those
principles earlier, you had about containing the unexpected when it occurs. And I think that in system safety, we can almost use a risk indices to say, well, the probability of this occurring are so remote that we can do this.

And it seems to me that HRO principles are in conflict with that, where we should be actually working on those things that are going to be unexpected and how are we going to manage it when they do happen. So, I just thought that was an interesting distinction between HRO and system safety.

MR. CARNES: I am not sure if I exactly how you -- sidebar I look at it this way. Is that I'm a big fan of risk assessment, you know, I go to the biannual, you know, PSAM, Probabilistic Safety Analysis Management conferences, and I think it is made a tremendous amount of difference of risk informing not only our inspection, our regulatory processes, but management you know -- that said, whatever we can expect, whatever we can
analyze, we can plan for.

    But it is not the things that we understand that bite us. And there are things at all levels, regardless of whether I'm a mechanic or whether I am the CFO that I may think I understand that I don't. The key distinction that I hope to draw is that it is that feeling of uneasiness, that humility in what we know that we try to engender through the kind of culture that Robert was talking about.

    When I talked about assumptions, I will leave it with this, is whenever we are making important decisions and doing critical work, you know, always trying to understand what do we know versus what we do not know and why is it that we trust the defenses that we put in it place is a difficult conversation we have to have and to have it continually. Thank you very much.

    MR. FLANIGON: I think down there.

    Jackie.

    MS. JETER: Thank you. I first wanted
to tell Mr. Sunwalt, I will make sure you get a picture of an operator to put in your slide.

(Laughter.)

MS. JETER: The second is going back to what you know and how you know. How do you know when you have a system that is practicing the safety culture and, you know, the high reliability and all of those things, because there is no reporting mechanisms for anyone? And, so, I know common sense tells me it is a system that is not having any accidents, but from this accident, I know that is not true.

Sometimes it is the accident that is waiting to happen that just haven't happened yet. So how do we know as an industry who is doing the right thing and who is doing the wrong thing.

MR. SUNWALT: Jackie, that is a great question. And I don't think I have a real good answer for that. But I do want to bring up that I think a metric for safety -- that the wrong metric for safety is a lack of accidents. And I think
that is what WMATA fell into. Our last fatal accident was January the 13th, 1982, and that has become a long time ago. And so, therefore, we are safe.

You know, we heard -- when we met with the board of directors 4 weeks ago, we did hear some of the board members say that. We thought we were safe, since we had not had an accident in a long, long time.

So, I wouldn't suggest that lack of accidents be a metric. I think it is quite contrary, and it is what Earl said a little while ago. Years ago people used to think that if we are not getting a lot of reports, that is good news; but in reality, that is bad news. You want lots of reports.

And really you never know what you don't know. And that is the scary thing. So, therefore, you want to get as much information as you can possibly analyze to look for those trends.

But it is a great and that is why I
think this preoccupation with failure, which is a characteristic of HRO is good, because you never are completely satisfied. I think when you start feeling like you are safe, that is when something is going to bite you.

I hope that gives you some answer to the question. I don't really have a good answer for it, other than we keep looking for information.

MS. JETER: Thank you.

MR. FLANIGON: Ed.

MR. WATT: Yes, for Robert, and anyone else can jump in if they have any thoughts. Is there any literature on the effect of psychosocial factors and other occupational attributes that contribute to a subculture? I mean, being a pilot, you know, there is a subculture there, there is a subculture with train operators and track workers, but they are all different. And they are influenced, obviously, somewhat by who is drawn to the job, you know, the nature, but they are also affected by the nurture, what happens to
people when they are on the job, what is expected of them, how they review justice, procedural justice.

So do you have any research or thinking how that -- how those connect the subculture to a culture of -- to the entire organization of organizational culture?

MR. SUNWALT: I really don't -- I will turn it over to Tony and Earl. I think Earl may know something on that. I really don't have any specific literature.

MR. WATT: Well, let me give you a little help, which I didn't want, because it is a bad example. And as the lawyers say, bad cases make bad -- is our friend the flight attendant who pulls the cord.

Well, you know, obviously, things just happened to him. And it is a bad example, because he is probably wrong on a couple of levels. But still, unfortunately, there is -- and I don't -- I don't find myself often in sync with popular
culture, but he became idolized to some. He was elevated to a hero.

And there has got to be something in there that people said, yeah, that is parts of my job that I don't like and they have done that. That is kind of the things I'm trying to get at, and would it be valuable to measure that, I guess?

MR. SUNWALT: One attribute of a safety culture which is -- you know, I had to boil this down in a couple of (inaudible) points but I think in other research that I have seen, work done by Dupont, one thing that is very important is procedural compliance. And I think that you can measure procedural compliance for a number of things through audits and focus groups and things like that.

So there is a linkage between complying with established procedures and safety, I believe. And Dupont has done work on that.

I am going to turn it over to these folks and see if they reference to something else.
MR. FAZIO: I am far from an expert on this, but I know there are behavior psychologists that work with culture science. It is behavior. And I read a report on -- in fact, a submission in aviation -- attributes you can look for to see if you have a safety culture. That is more of a macro, I think. You are looking more at the micro. I don't know how to address that one.

MR. CARNES: I will be happy to share literature with you, but let me start off with Dr. Edgar Schein, MIT, the macro level of organizational culture. He is probably one of the -- he is known for collecting (inaudible). Ed Schein, Dr. Ed Schein, I can give you the information. He is (inaudible) gentleman. He gets into subcultures discussion.

So, that approach is one level. Friends of mine in Finland, (inaudible) have some excellent -- primarily solution and procedure operation where they discuss different techniques that you can use to go -- and I'm big, as you
probably can tell, going into the workplaces and
interacting and trying to understand what the
subcultures are.

So, they have had some interesting ones,
particularly on maintenance culture, how to
understand maintenance culture, and again, that
work that is imagined versus work that is done,
and also understanding, as you were saying, the
assumptions that you may have subculture in
maintenance organization.

So, there is that kind of literature and
it is on psychodynamics, that kind of stuff out
there, we can -- my kind of business, you know, I
don't think you would go that extreme, but you
know we have psychologically profiles based on
people that we allow to do certain kind of work
and all of my prior life, you know, what goes into
the standard, you know, in the VA and all of those
kinds of thing to make sure that, you know, the
appropriate things -- of course, in our -- so,
yes, there is a body of literature. I can help
MR. FLANIGON: I think Diane is up next.

MS. DAVIDSON: I'm interested in how you operationalize the safety culture, and in particular for FAA. I believe you have nine regions. What role do the regions play in safety, in carrying out the various directives, because you have a very large population? I think you have four regulatory disciplines or four disciplines that are then regulated. So, what role do the regions play?

MR. FAZIO: Trying to think back. It has probably been about 15, 18 years ago we centralized all policy and procedures into Washington. So the regions themselves basically perform that policy or enact that policy. So, what you see, unfortunately, and one of the biggest criticisms you will see in aviation is that one facility or one office will apply regulations differently than another.

And, so, one of the reasons why we
decided to go to an ISO quality management system
was try to pose a standardize process. So, this
is the process for certifying airplanes. This is
the process for certifying aircraft or parts, this
and that. Everybody follows it, and we test
ourselves against it by evaluation.

So we attempted to do that and have we
been successful. I think we made progress. We
have a lot further to go, obviously. We still
hear stories that (inaudible). I think a lot of
it comes down to leadership. We as a safety
order -- I'm not speaking of the whole FAA, I'm
now speaking of the a safety organization, we are
7,000 strong. So we have a lot of
responsibilities for the airplanes and the
manufacturers.

We do a lot. We try to get out and
(inaudible). As a member of the executive team,
we go -- we have been asked by my boss, who is the
director of safety, to go out and meet with ever
facility out in the country. There is over 100.
So, we are taking time out to go out and preach the same gospel, if you will.

So, personally, I think a lot of it comes from -- if you have all policies and procedures, it is great, but at the end of the day, it has to be leadership. So, you have to get your middle managers to (inaudible). In 2 weeks we are bringing all the middle managers from around the country into Washington to begin this dialogue. It is a very, very difficult job.

MS. DAVIDSON: Kind of a follow-up for that. In terms of compliance and after enforcement is conducted, I believe you have something called airworthiness directives. Do you still use those?

MR. FAZIO: Yes.

MS. DAVIDSON: And if I understand that, it is not a fine-based system, but it is corrective action system. Are fines involved in that, and if so, what looks to be most effective fines or certain conditions of not being allowed
to fly or other associated actions until compliance is reached?

MR. FAZIO: Well, an airworthiness directive basically is a regulation, so an aircraft certificated is supposed to meet a certain level of regulations, of standards. We should have airworthiness directives to say, well, we missed it. We didn't get it right. The intervals are not correct. We have to do less or more, whatever it might be that brings it to the level of safety to where it is certified.

So, that is a little different than -- fine for that. We, the regulator or the industry manufacturer did not see that occur, so we have to fix the problem immediately to do that for rule making (inaudible).

I think where you are going is more of the enforcement, civil penalty route. You know, that goes up and down. There is a period there where we enforced a lot, we imposed possible penalties, and we adopted the just culture. We
are trying to find that happy medium. I don't know where it is.

I mean, we just issued announcement last week, I believe, $24 million to American Airlines. It is the largest on record. And, so we found it pretty egregious. It will have to work its way through the system, but -- if they were not compliant with an airworthiness directive. So it goes up and down.

My personal view is I think you can do a lot with just culture. Why? I don't think anyone wants to break a rule. I mean there are bad actors, there is no question about it. I would say 90 to 95 percent are trying to do the right thing. So, you know, you have got to have a measure --

MS. DAVIDSON: Thanks.

MR. FLANIGON: Bill is up next.

MR. GRIZARD: Mr. Fazio, I apologize, I was thinking maybe my question I want to direct you, but I feel like you are drawing all of the
MR. FAZIO: No, I'm sorry the part of the regulation it is called Part 121.

MR. GRIZARD: Oh, Part 121.

MR. FAZIO: It is any airline operation nine seats and above.

MR. GRIZARD: Okay. But I'm guessing that there is going to be -- quite a bit of difference between airlines if you are going to be applying this to or you got the smaller regionals and, of course, the larger internationals and a variety of different kinds of equipment and operating procedures. And I am just wondering if you have given any thought to how you plan to apply some kind of scale and flexibility of the SMS to that universe that you are responsible, what kind of approach are you going to adopt?

MR. FAZIO: Yes, that is -- what I
failed to mentioned is that one of the reasons why we think we can meet the 90-day deadline is that we had our own advisory committee already in place made up of airlines, manufacturers, the whole aviation community and fair statement.

And one of the first recommendations they made to us is whatever you impose on us has to be scalable. So clearly, we do believe we are going to get there simply because it is going to be a performance-based regulation, so obviously, if you at Boeing, you are not going to have the same SMS as a mom-and-pop manufacturer of a bolt, for example, which happens in our industry. And, so, we recognize that.

Again, while the rule will be performance based, it is all in interpretation. So, I know I just recently heard from the helicopter industry, they have already put out guidance for their members. And they have a road map, if you will, for applying SMS for their community. And I love to share this story. They
are so adamant about this, they had a one-person, one-aircraft operation. He has an SMS.

As pilots, you have a checklist. That is an SMS in a way isn't it. If you are talking to folks who came from the military, the test pilot, they give you one page. You have to fill it out, if you get a certain score, you are not flying that day, because they ask a question about fatigue or you last flight, whatever it might be. That is a form of SMS. And that is scalable. So, I think that is what we have to do and we are very mindful of that.

MR. FLANIGON: That was good. I appreciate that Bill is thinking about the task at hand, because we have got -- just at the table here, we have the largest transit operation in the country, and in terms of rail transit a very small historic operation of streetcars, so whatever we come up with has to fit that broad spectrum.

I think I have one over here, Mr. Dougherty.
MR. DOUGHERTY: Thank you. Again, Mr. Fazio, I guess --

MR. FAZIO: We are all regulators.

MR. DOUGHERTY: Well, I guess that is it. I believe you said your primary function of the FAA is regulatory function; correct?

MR. FAZIO: I'm currently accident investigation.

MR. DOUGHERTY: And you have, what, 4,800 inspectors or something?

MR. FAZIO: The safety organization has roughly 7,800 inspectors.

MR. DOUGHERTY: And the regulated community, are they all private carriers versus tax based or tax supported?

MR. FAZIO: They are all private entities, yes. We do not regulate public (inaudible).

MR. DOUGHERTY: So I guess looking at that, that's some of the differences. And are all of the inspections conducted by FAA inspectors
versus others?

MR. FAZIO: Well, that is a good question. No. We have primary (inaudible), but we do a lot of delegations. So, for example, if you are a pilot and you need a medical exam. You don't go to FAA doctor. You can go to a doctor who is certified by the FAA -- designated by the FAA to perform that.

If you are a pilot and you need a check, you can get checked by someone who is working on behalf of FAA. You can do in the manufacturing center. There are designated engineering representatives who, when they are getting approvals for certain production or engineering approvals are doing that on behalf of the FAA.

So, we do a lot of that. Remember I talked about the changing aviation industry. We are going to more of that, because we are not growing. If you follow what is happening in Washington, the government is not going to grow. The industry grows, we have got to adapt to meet
that. So part of that is designation.

MR. DOUGHERTY: Thank you.

MR. FLANIGON: And I think Mr. Clark is next.

MR. CLARK: Thanks, Mike. I guess this kind of a question and an observation for the panel itself. Kind of picking up on something that Jim mentioned which occurred to me also is that in this industry we are in a very different position. As a regulator in California, I regulate public entities, tax-based entities not -- well, on the rail side of the operation I do.

And so that is very different, because it is very different to try to assess a penalty to take an enforcement action against another governmental agency than it is a private company. But it occurs to me from listening to what you-all have said, I have been an enforcement guy for forever, and I have always struggled with the enforcement, the collaboration, the
performance-based rule making, the enforcement, and the whole 9 yards and how it is that you do the enforcement.

But it occurs to me after listening to you folks and some reading that I have been doing that if you have collaborative rules development, you have performance-based rate making standards, and then as one of you said, I think I was you Mr. Fazio said, clearly written interpretive bulletins and materials, and then you have corrective action plans, that you find yourself in an excellent place to take an enforcement action if you need to take one. And the possibility that you would need to take an enforcement action I think is diminished considerably by having these other elements of a system in place.

I just wondered if you might comment on that?

MR. FAZIO: I think you have done an excellent summary of what we have been trying to do. As I said, my belief is 90 to 95 percent of
our community wants to do the right thing. And, so, getting there, you know, if it is a lack of information or a mistake of sorts, you have in place mechanisms to do that. So, we do a lot.

When I was in rule making, for example, we do a lot of rule making by advisory, bring in the agents. They can tell us. You know, people wonder, well, isn't that a conflict of interest, industry is coming in? No. We are using your expertise. We ultimately have the say.

So, yes, I agree with you. But I don't know why as a public entity you couldn't have the authority to point to situation and say, no, you are not doing. The state is different, obviously, but --

MR. CLARK: I'm not saying we don't, because we do actually stop operations from time to time. But assessing a monetary penalty is a whole different thing. But shutting them down until they fix something, I mean, I have certainly done that.
MR. FLANIGON: Jackie I think is next.

MS. JETER: My question is when we started the FTA DOT drug testing policy, with that we also put -- and I say "we," but you -- put in a caveat that after a period of time there will be an audit, an audit of the agencies that are participating to find out whether or not they are following the guidelines that have been put in place and how they are following those guidelines.

So my question becomes, do you support or what is your thinking on that type of audit being put into place with regulations for transit agencies around the country to find out whether or not they are complying with federal mandated guidelines or regulations?

MR. FAZIO: Is that for us.

MS. JETER: What do you think about it?

MR. FAZIO: Well, unless FTA were to give regulatory authority, which I doubt (inaudible) there are other opportunities out there for you. You have trade associations.
There are a number of ways that you can do it where you can have third parties come in and audit you.

I think maybe as a community you may want to help establish standards. I'm sure FTA has regulatory standards with guidance materials. I have seen some (inaudible) trade association. Have a third party come in.

We -- I'm involved in an advisory committee on the future of aviation, and we had an interested presentation from the Flight Safety Foundation 2 weeks ago, where he was making that very point, that we are getting to the point in aviation where it becomes so safe -- my friends in NSTB might not want to hear this, but is getting harder and harder for us to issue regulations, because if you are not aware, we always have to deal with cost ratio with any regulation we impose. We cannot get the benefits because we are so safe now, unless there is an accident, an immediate accident that we are addressing, it is
very hard for us to justify that.

So his point was, well, why don't you have the industry police itself. It is a very interesting concept. I'm not sure we will go for it, but -- and the idea falls around best practices. Why should -- I spoke of those programs. Why should an airline that is doing all those right things then compete head to head with a company that doesn't do that? Those programs cost a lot of money. But they are not regulatory. We are not mandating these.

And, so, the industry itself could say, you know, this airline or this train authority follows the Good Housekeeping seal, if you will, and then the public can decide. You have an informed public there.

We do it -- the International Air Transport Association does that for their members. You cannot join the IATA -- you may have seen that on your ticket -- unless you passed one of their audits. And they bring these safety audits,
business audits, that sort of thing. And, so, you
cannot be a member of their association. So there
is another premise. I don't know if it is your
model or not okay.

MR. FLANIGON: I think what we are going
to do is take one, two, three, four, five more
questions before taking a break. And we will
start with the duty medic.

MR. BATES: This question is for -- it
can be for all three on the panel. And, Mr.
Sunwalt, watching your presentation, I was very
fascinated by it. In your study, who is the chief
safety officer in the company, is it middle
management or is it CEO.

MR. SUNWALT: In my opinion it needs to
be the very top. Now, that is debatable. Where
is the top? Is it the general manager, is it the
board of directors? Where is it? And I literally
mean it has to start at the top of the
organization. In my opinion that is the board of
directors getting the right information and
providing some level of oversight into those issues. It has to be the CEO.

Safety is not just -- as we said in our board meetings, the chief safety officer is there not to be the head of safety, but to be one who supports the head of the organization to make sure that they are looking at those right kinds of things. Safety is not a middle management function.

A chief safety officer is there to collect the data, and then make sure that those higher up in the organization are fully informed as to what they need to be informed to.

MR. WATT: That is the problem I kind of have my reservations with, because the board of directors, are they a day-to-day operation type -- are they a day-to-day operation type function or is the general manager or the CEO day to day to keep his eye on the process on a daily basis?

MR. SUNWALT: Well, I think the general manager is certainly there to look at the
day-to-day operations but if you look at any books on -- I was out looking at some colleges with my daughter, and she wanted to go to Harvard, and I hope she can get in there, so we were in Harvard bookstore, and I picked up a book on governance by boards of directors.

And one of the functions, governance functions of the board of directors is to provide oversight. And it's sort of odd, we usually have a board -- a committee to look over finances, a committee to look over property and real estate, but is there a distinction committee to look specifically at safety?

And in my opinion that is part of your fiduciary responsibility as a board of directors, is to manage safety just as you manage the other vital business functions in that organization. And if you are not, then I can assure you, you are not going to have a good safety culture in that organization.

MR. BATES: I have one more point also.
I keep hearing about the third party, and someone coming out and looking at -- what is the employee's role in the safety plan, because you already have experts already on the property that can tell you what is wrong or what needs to be fixed or their concerns?

Do we have a system or a process in place that it could -- it could come from employee up back up to board of directors or to the general manager, because we have a bunch of experts that work there every day, they complete those tasks every day, and 99.9 percent of them does its safely every day. But also there are times when something is unsafe. How do they report that to someone to change the culture or change the situation itself? What do you find about that?

MR. SUNWALT: Well, I do believe, and I'm going to go back to something that I have said earlier today, and that is safety does have to start at the top and it does have to permeate throughout the entire organization.
With that, I will go back and look at the couple of the definitions that I proposed to safety culture, and that is that it really does have to be an overriding priority with everybody that works in the organization, and it has to be a set of core values and behaviors resulting from a commitment, collective commitment of our leaders and individuals to emphasize safety over competing goals.

And I realize safety is not just the chief safety officer and it is not just the chief executive officer and board of directors. It has to be every person touching that organization, including contractors. It has to be an override priority. I know that sounds very esoteric and academic, but that is what we are striving for.

I hope that gives you some clarity, from my opinion at least.

MR. BATES: Okay. Thank you.

MR. FLANIGON: Let's work our way around the table Jackie. Rick.
MR. INCLIMA: First of all, I wanted to thank all three panel members for excellent presentations and preparation. I really appreciate it. It was very helpful. And I think you have kind of captured the challenge that we face.

You know, James Reason has been around for a long time, the whole concept of safety culture, particularly changing the safety culture from where we are to where we are going has been an illusive goal, both on the transit and the railroad side; you know, the whole items of non-punitive reporting and analysis, cause analysis, and improvement, et cetera.

But the reality I think and the challenge we face is discipline is easier to manage than safety culture and change, you know. And I don't know if anyone has any advice for the group about how do we transition from the discipline way, you know, blame it on the pin puller guy, if I can blame you, then as -- you
know, whenever I sit, I am good.

I mean, how do we address that? How do we transition from where we are to where we would like to go? I mean, what incentives, you know, whether they are negative or positive incentives, can we introduce into the mix to move where we all like to go?

I don't know if anybody can answer that.

MR. CARNES: I will just go over this for observations. Things that I have seen in the work is find someone, an appropriate senior level in the organization who is a thinking person who sees the need to change. Equip them with education, training and tools to enable them to perform what I call controlled organizational experience to demonstrate that these practices do have positive benefits of safety and performance.

Shine the light on that individual leader or (inaudible) and make him the hero or her. Get the internal competitiveness going. And I have extended that to the organization.
Now, the way that I work with the Department of Energy is all of my work is for the people who volunteer. Let's face it, it is big dollars, okay. If you are going to be a contractor for the Department of Energy, DOD, whatever, it is big dollars. You want to demonstrate that you are doing the job well and you are doing the job safely because you want it to work.

There are people who out there who understand the bottom line. Okay. I just you know I look at the bell curve idea, there are certain early adopters who are working these and when you see them doing this, see them shining the light (inaudible), meanwhile we go for what my colleagues do here, and when you have an event, which unfortunately happens, you use these principles in doing your invested interest to show how the very things that are failing are the things that the successful people are using to succeed.
So there is no simple answer but mine is run by early adoptive people who want to make things happen, do it that way, plus you always have the regulation and the inspection to work the other way.

MR. FLANIGON: I think the penultimate question comes from Tom.

MR. PRENDERGAST: It is really expounding on the dialogue Tony and Jackie had, and you asked the question about self-policing. I have had the benefit of working both in a the regulatory and non-regulatory environment, first in -- actually most of my time has been in rail transit, but I did have 5 years in FRA environment.

And in 1994 we had two real bad accidents that forced the whole actually outgrowth of RSAC. And there was a recognition on the part of the senior executives and the safety officials that in order to get to the next level of safety and get to the point where we make sure that we
were putting in processes, procedures and regulations that were worthwhile. It had to come from the side, recognizing that the FRA had a role to play.

And at the very basic level, there was a terminology used that the pain we give ourselves may be followed by some of the pain that others will give us, because we know more about it. Much like, I think you raised, Earl, the point of some of the best experts we have in the system are the people who live with it every day. I know an awful lot about track maintenance, but I have never been a track maintenance employee.

So those people really have a very good handle on what needs to be done. We need to give them the resources, the policies and the support.

I also worked at the FTA years ago under UMPTA (phonetic) and it was no different then than it is now, in the sense that there was a reluctance to get into the regulatory environment.

In the standards development on the rail
transit side, we have consciously tried to adopt that philosophy, which is self-policing, because if we have a standard that everybody asks for waiver or some level of exception to, we don't have anything.

So I think this committee -- I mean, that is one charge I think we ought to take to ourselves, that we will be only as good as our ability to enforce on ourselves that which we prescribe for ourselves in terms of a standard. It is the old adage, you have the walk the talk.

MR. FLANIGON: And the ultimate question, Mr. Cheng.

MR. CHENG: Well, we talk about safety management system, we talk about risk management. Of course, you know as to risk management basically we use the data accident/incident information.

I would like to know practicing the FAA and the Energy Department? How do you have this -- how do you use that and how do you collect
information?

Also, when we talk about -- when Mr. Sunwalt talk about reporting culture, I would like to know if your department has that kind of system to allow employees in the industry to make reports, because as I see, it is kind of -- on the highway side, it is good.

It's a good system because, you know, they have NHTSA, National Highway Transportation Safety Administration. They have a system, you know -- and public can enter -- if they have problem with the vehicle or anything, they can enter that and then looks like they have discipline personnel to analyze that on a daily basis, so that is how -- you know, the Toyota gas peddles and a few years ago Firestone tires, that is a result.

So, I would like to know the department's practice in terms of that?

MR. FAZIO: Well, we use data all the time. I mentioned a number of examples up there
where obviously it is confidential submitted information. I would argue probably we have too much data, in that as a government agency, you know, you will have a requirement that was imposed 20, 30 years ago that never goes away.

We have -- you know every time something happens, you are correct, we have a requirement. So, one of the things I want to do in my current capacity is start looking at all of the required data sources to see if they are still valid, because I think as a government agency, we (inaudible) administrative a lot. You are not aviation people, but there are some (inaudible) where they say, wait a minute, no more reporting.

Having said that, we are still required -- we are going to require reports. The only question is what kind.

And so, to get to your point, yeah, we look at it all of the time. I mean, Robert spoke about the engines. I mean, we have engine reliability information, our engineers they deal
with that all the time. That is how they deal with risk analysis. So, we have got the information. I would argue we might have a little too much. And part of what we are trying to do with the (inaudible) program, the idea is taking all of this information and fusing it together, is it giving us what we need? Because if we can tweak some of the data sources, we might be able to get better information. So I don't know if that is -- but we have a lot of data sources.

MR. CARNES: Just quickly. In the Department of Energy and others we have what I call -- we advocate a nested series of reporting systems and subsystems; in other words, we have certain things there are both regulatory and required reporting. All right. We all have those threshold.

Some of those are in terms of engineering systems, (inaudible), environment, those kinds of things, but we also have certain management systems that we want people to
cooperate and report on. And within that we have a management discretion area, that we actually get people to report to us on things that they have identified as being concerns to them that are not defined in the regulatory threshold, which we really want to encourage, because they, say, huh, we have concern about this, and so we are telling you we have a concern about it. And we consider that to be a very positive behavior.

Then going down, so we look at this at each department in an organization, do we have maintenance, engineering, et cetera, right. We expect them to have reporting systems and metrics that are relevant to their particular discipline, like maintenance, so we have predicted maintenance, we have observance maintenance, surveillances, on time surveillances, all that kind of stuff so that the maintenance department may have a few hundred metrics, and it is just maintenance kind of stuff.

Then, I should say we encourage, support
innovation as to developing those very small reporting evidence. So, at one very, very large facility they have been a lot of the work in the past couple of years of building upon work of Jim Reason and in looking at what we call error being something happened or did not -- something happened that we didn't expect to happen or something did not happen that we expected to happen, we will call that an error. Okay. It didn't cause a consequence, but it was, again, that unexpected and reported at that level. As Jim Reason did and John Wreathall -- they did work on, I think the (inaudible) Singapore error, British error on a system called Mesh several years ago.

And I thought it was real deep because it gets into, you go and take a select group of people, and they come out -- and anyway, they tell you, well, gee, today I didn't really have training that I needed on this kind of system or I didn't have the tools or the supplies available.
So, it is that what was unexpected. That is the level of reporting we are trying to get to, so that helps. It is a necessary level we are trying to go down as fine as we can in discrimination of what was going on.

MR. FLANIGON: All right. Well, I want to thank our esteemed team panel for the time that they put in today. And we will take a 15-minute break, which would put us back here at 4:15. And before the panel may leave the building, I want them to know that they are invited to our reception at 5:00 o'clock in Room Number 5, one floor up, 5:00 o'clock Room Number 5. I wonder if that is a lucky number.

(Laughter.)

MR. FLANIGON: I know Earl has to leave town, but the other two if you want to stick around, you are more than welcome. If you want to circle back at 5:00 o'clock in Room Number 5, one floor up.

That is also 5:00 o'clock for any
members of public interest observers, you are all invited to meet and mingle with the TRACS committee.

So, we will reconvene here in 15 minutes. About one round of applause for the speakers.

(Applause.)

(The proceedings recessed at 4:02 p.m., until 4:21 p.m.)

MR. FLANIGON: I want you to know that I have -- according to the agenda, I have a discuss current 659 system approach and can SMS principles enhance it. And I put together this great 300-slide PowerPoint that I think you would really like.

(Laughter)

MR. FLANIGON: How many people want to see more PowerPoints this afternoon? Only one. Okay. No consensus. So we are going to make a shift in the agenda.

And actually, what I had put together
would probably be useful at the point where we form up a work group to look at the first task, the model. So all is not lost. We will make use of that information.

But what I thought would be a productive use of the next 40 minutes or so was to engage you, the committee, on helping us articulate the kind of pick up task two that we got this morning. We had spent a lot of time thinking about how we might format and articulate the first goal. But the second goal we are kind of picking up on the fly, and so I thought we could have a conversation about how to articulate that to help guide the work that will be get done.

And before doing that, let me just ask one more time Ms. Esther White, on my right-hand side in the back of the room is available to take anybody's name, members of the public who would like to make a public statement to the committee for the committee to hear tomorrow morning at 9:00, whatever the time is, 9:45, I think. So if
you would please see her if you would like to make a statement.

And otherwise we will kind of move in. So, this is more of a discussion -- this is audience or committee participation, not Mike talking at the committee. But let me -- let me start with what I think I heard. And then we can kind of work our way around and see how we might flush that out.

So what I heard was a valuable task for this TRACS group would be to examine, in the kind of same format we are talking about, the safety planning model, examine the best state oversight agency, organization, financial funding source, technical capacity, some of those kind of -- what are the characteristics or sort of best practices, I guess, will be as a state oversight agency? What should a state oversight agency look like to do the best possible job? That's kind of what I heard as a goal.

But we have got 20-some odd other sets
of ears that may have heard it a little different or picked up a nuance that I didn't pick up. Let me just throw that out to the committee. Any comments or thoughts? And we have a couple of state oversight agencies, starting with my home state, being a California native, Rich Clark.

MR. CLARK: What I heard Peter say was what defines a good state partner in terms of capabilities, expertise, relationships with the federal government and the transit agencies. Those were the notes that I wrote down. I just offer them.

MR. FLANIGON: And we have our folks taking careful notes of this discussion. And what we are going to do is try to translate that into this same format that we passed out to you as tasking number two.

MR. PRENDERGAST: Similar to what Richard said, but I thought he used the word "ideal," and so when I heard him use that word, I thought rather than look at trying to characterize
who would be the best, look at the best practices
of all the state agencies and cherry pick those
that would help to identify what would be the
ideal state safety partner.

MR. FLANIGON: Mr. Dougherty.

MR. DOUGHERTY: I guess, you know, just
exactly what I wrote down from what Mr. Rogoff
said was continuation of state partners and safety
oversight, i.e., SSO, what defines a quality
safety organization, what identifies a good state
safety organization/partner, need for -- and the
need for consistency. I think that is pretty
close.

MR. FLANIGON: Are there any other?

Rich? Pam.

MS. McCOMBE: This is a slightly
different question, but are we limited to just
evaluating the state safety oversight, or can we
also evaluate at the agency level what they need?
In other words, perhaps they need to implement an
SMS and dedicate funding for them as well.
MR. FLANIGON: I think that fits, in my mind, more into my first task, and I think exactly, it involves the agency, because with the agency is where the rubber hits the road, that is where it has got to happen. No amount of regulatory oversight is going to make the transit agency safe through -- it has to be the internal processes and how they. That would be my take on it.

Amy.

MS. KOVALAN: Thanks. Along the same lines, when I heard the administrator talk about defining the ideal state safety partner, I know that in markup some of this changed, but as the legislation moves forward, some of the flexibility of having different laboratory models -- so, you may have a large state with a lot of agencies, one model SSO, but it would be nice in the idea of talking about those partnerships with the state not to rule out a model similar to what we just heard about at the FAA, if states opted to do
that.

States where maybe there is only one agency in the whole state being regulated, for example, and it might make more sense to deal directly with the region of FTA or something like that.

So, I think looking at that question and what the options are and keeping that open, it may not be one size fits all.

MR. FLANIGON: That is a really good thought. And it parallels, I think, one of the points we were trying to lay out on the first task, which was the planning model that would be in place at the agency. And, you know, the point I made earlier that we have the largest transit agency in the United States and one of the smaller operations at the same table, and somehow whatever we do is scalable and appropriate.

The same is true of state oversight, because we have the state that oversees one of the smaller transit operators, and then we have the
state that oversees one of the largest in the country if not in the world. Is New York -- where is it on the world map?

MR. PRENDERGAST: It depends on what you measure.

MR. FRANKLIN: But somewhere up there, if not the top, near the top. So I think the ideal state oversight agency concept has to be scalable based on what are they overseeing. And that is something I have given a lot of thought to as we have, you know, worked on legislative models that would, on the one hand give states the opportunity to opt out, and another model which is (inaudible) no states opt out, therefore, it has to be a state oversight agency in the state that may have little in the way of rail transit and operations.

So, what is the right mix of resources? You know, we don't expect -- we wouldn't expect the State of Wisconsin to stand up a 10-person oversight agency for a 2-mile streetcar line. So
how to put the right mix of federal involvement, I
guess, or support and what is the right mold for
contract support.

Several people have asked me that today,
where should contracting fall into this whole
thing. Currently there is a lot of contracting of
audits at both the federal and at the state level.
So, what is the right mix.

I'm sorry Mr. Pearson.

MR. PEARSON: I have one comment to make
on state oversight. First of all, the sat
oversight agency itself has to have their plan
together. That is one of the main fallacies that
we found now. The state oversight in Tennessee,
it basically only deals with only two small
agencies. You know, they deal with MATA and they
deal with CARTA, which is the incline railroad.

One of the things that we found most
helpful is that they have a clear understanding
through the training that they have gone through.
They don't have the day-to-day expertise, but they
have ventured out to take as many training classes
as possible offered by FTA so they can get
familiar with what they are monitoring. You have
the numerous individuals that monitor systems, but
they have no clue of the day-to-day actions.

The success of our SSO has been that
when they did not understand, they at least came
by and allowed you to carry them out and actually
let them work with you, where they could get some
clarity and understanding of what they were to
monitor.

Therefore, that brought about the
cohesive work relationship where when we did not
have dollars in the agency for additional
training, they would take dollars out of the
training pool at the state agency and supply the
two agencies with necessary training to bring our
employees up to a standard that would we would
consider acceptable.

So, if that is not -- if you don't know,
you can't regulate. And if you don't have a good
work relationship with the agencies that you are
dealing with -- and that comes through trust and
honesty.

Now, there is no comradery -- I mean, there is no collusion there -- let me use the
right term there. If we do wrong, we are written up. But we work together so well until we don't
want to do wrong, because our ultimate goal is to have a safe operation and follow the rules and
regulations in our SSPP and SEPP. And they just make sure that they hold us to that.

But if they see that there are some fallacies, they are willing to work along with us. I think that we need to bring that out. Now, New York and some of the bigger agencies it may not be user friendly, but I think the premise is, and we involve every entity, the labor, even public relation, HR, everybody is involved in our safety committee to the point because without those people playing a valid role, we still get junk in, junk out. And we found that we had to
team up to get total consistency across the board and believing.

Now, the safety person is responsibility as well as myself and the general manager, but -- and they brought up something -- I'm going to take the time to say this now. Our SSO comes to our board once a quarter and reports to the full board of directors of our agency.

Because I don't know about anybody else here -- I have talked to one or two people -- I don't know any board that deals in day-to-day operations. Most boards are political appointees and the only time they are going to talk to you about operations when you have disaster or something going on. And that normally means you are going to fire the general manager and get somebody else in.

But we tried to be proactive to the point that at least once a quarter, safety is put on that agenda and the SSO themselves come down and talk to the board about our safety functions
and what we are doing, what we did wrong, what we
did to improve what was wrong, and what they did
to assist us in doing so. And I think that is
very valued.

MR. FLANIGON: Thank you. Let's move
along the table here. Jim.

MR. DOUGHERTY: Thank you. I think if
you ask the right mix, the right role, and -- I
guess the concern that I think probably the
regulating agencies would have is where the FAA
has their own inspectors. If the states are going
to do that, that is fine. There is a concern,
though, when a state is using contractors that are
for profit that are doing an audit, and follow up
on the audit, and I think that is something that,
you know, that is discussed in the transit area.

So, I think if that is to be the case,
that whoever the contractor is that may be
involved in the audit, that they wouldn't have the
role of following up on the audit, because, you
know, whether or not it is perceived or real, is
the more you find, the more work you have.

And, you know, if they can't be state employees such as the case in the CPUC, you know, where they are all state employees and contractors have to be used, I think we need to kind of put in some kind of a -- or look at the option of a safeguard, I guess, if you will, to insure that it is not, you know, the more I find, the more work I have for a longer period of time or for perpetual work.

That would be certainly a concern that I have heard, that I share as we look at the regulation. There is a difference where the FTA is, you know, a lot involved in grants and development versus the FTA -- I'm sorry -- the FTA, yeah -- grants and development, FAA's regulatory if there can't be a regulatory arm of the FTA, which may be a good way to go and hire, I don't know, 100 inspectors or whatever like in the surface transaction inspectors on the DHS side also. But something along that line is, I think,
something that this committee would need to look at.

And then how do you penalize or how do you compel if there is not a accomplishment? Does it make sense to fine one governmental body to fine another governmental body, when everybody is struggling for public tax dollars already anyway.

MR. FLANIGON: Thank keep going down the table. Georgetta.

MS. GREGORY: First of all, I think it would be important for this committee to have some discussion as to what the group collectively thinks the state oversight agency should look like. And to that end, would we be looking to have, as currently exists, an agency that would oversee the system safety program plan or a regulatory agency or a mix of both?

I would propose that, again, the geographics, the number of systems, the track miles, the number of employees and all of that has to play a role into that.
If you are going to have inspectors, those have to have a specific skill set that you don't just hire off the street. Generally you are going to have to either draw from the transit agencies or from one of the railroads to get that specific skill set.

Then you need the engineering aspect, the professional engineering aspect. And you need a nice blend analysts to go along with that as well.

But I think before we can make a recommendation on that, we need to have some discussions on what we think you should have. Should you just be a paper chaser in the form of record audits and system safety, or do we want to recommend actual on the ground inspectors? The training is huge.

I have to echo Jim's comments about the use of consultants for these activities, being brand new to this side of the dark side have been accused, I have had my first experiences with the
consultants. And I have to parrot exactly what Jim said. The audit of MARTA is coming up later this month, and I have some trepidation that the findings will be long-term work for the consultants and not necessarily safety critical.

That is what I'm looking for from a good state safety oversight. I want the safety critical items. I don't want a laundry list of little nitpicking. You didn't indent your thing here or you didn't define state or some silliness. I want safety critical information that I can put to use immediately to improve the system.

So anyway, I basically have the same notes from the administrator's comments. You know, he wants a definition and a model of what a good state safety oversight agency would look like, so I think we really need to have some discussion on what we think it should look like.

MR. FLANIGON: Henry.

MR. HARTBERG: Wow, you just made me mad all over again, Georgetta, because we had a group
come in and do the type of audit you are talking
about, and I guess it was safety critical in some
places, in our SSPP, our technical services group
was called a group and in a few other places the
was called a division.

(Laughter.)

MR. HARTBERG: I sort of wondered -- you
know, I tried to imagine the accident where the
NTSB would say the cause of this accident and so
forth.

What I wanted to talk about a little bit
is the scalability issue. If the FTA is going --
if the opt out portion of this bill makes it
through, it is out -- it is gone? Never mind.

(Laughter.)

MR. HARTBERG: I was going to stay if
the FTA is going to have to do some of that
oversight anyway, they should -- you know, there
is expertise that you would need so. If at that
point -- one way or the other with the smaller
groups and really for, you know, even the states
that are large but don't have a lot of properties, there is no way to make the states willing to -- as is willing to devote 10 people so they have an inspector and they have an engineer, and so forth and so on the staff for, say, two properties like we have presently in Texas.

So one of the things that would be good, I think, is that if the FTA somehow made available certain types of expertise so that the states who can't justify a California PUC type of arrangement, still have access to quality information and quality assistance when they need it. That way you are sharing a few people with the states that don't have so many properties to deal with.

MR. FLANIGON: That is a good thought, and that could very well be something that the work group would -- I would hope take a look at and make some suggestions in that area. Tom.

MR. PRENDERGAST: -- with Georgetta, I think one of the ways maybe to do it is we could
not do an exhaustive series of presentations, but you have the gamut to deal with the scalability issue, and not only the history issue.

I don't know for sure, but the PUC has been around a long time, probably 30 or 40 years, I guess, since the creation of BART. In your evolutionary history I'm sure you would change your approach and you will learn an awful lot.

But to be able to hear from you and when you get the New York State Public Transportation Safety Board, both the person at the state level as well as those at the agency level themselves about how that evolutionary history worked and what did work and what didn't work, and what is the proper balance for providing the necessary oversight. And the FTA has to be part of that discussion.

A number of people have touched on it, but the thing we have to be careful of is that there is a finite number of people that can spell system safety, let alone talk about it; there is a finite number of people that can talk
about safety management systems, and what we don't need to do is -- we need create a higher level of intelligence across a broader scale. And we are all trying the do that.

But if we don't think about how we can balance those resources at a federal level, a state level and a local level, that unbalance and the quality of the resources is going to cause us problems.

What I would propose is that we identify a representative sample of state oversight agencies, that you come and give presentations in concert with the agencies that they have oversight responsibility for, what works, what doesn't work, whatever, to help provide that level of experience and knowledge that they can help us define what we want to do.

MR. FLANIGON: Thanks, Tom.

The interesting side of the California PUC used to be the California Railroad Commission. That dates back to Johnson --
MR. CLARK: 1911. We are in our 100th year.

MR. FLANIGON: To counteract the evil Southern Pacific Railroad that was the octopus of (inaudible) that had its tentacles into politics in the -- by constitutional amendment, the PUC headquarters has to be in San Francisco; it cannot be in Sacramento, so it is not contaminated by the politicians in the state capital.

Rick.

MR. INCLIMA: Thank you, Mike. You know, I am probably at a bit of a disadvantage not having a lot of experience in the transit side, but I -- you know kind of echoing some of the comments, I think it would be helpful if we could get, you know, an outline, if you will, of existing state oversight organizations, you know, what they do, you know what is their scope and level of responsibility, and you know, maybe how -- you know, to what extent they interact with FTA, et cetera, because I think it was Tom who
said it earlier that it sounds like the task is let's look at what is out there and let's cherry pick the best of what is out there and say this is what -- to the extent we say, this is what we should all be aspiring to.

And I don't know how we do that, unless we start with the baseline of what is there now, you know, so we can start saying -- picking and choosing, well, you know, they have a very good program in this section and they have a very good program in that section, and let's build a model and hold it up there as an example of what the agency and the committee would like to see.

I don't know how difficult that would be. But it certainly, I think, would be helpful for the group, because you know, as a starting point. Because the guy in California probably, I'm sure, has a great program, but he doesn't know what is going on the Connecticut, and vice versa.

MR. FLANIGON: Good point. We actually have some comparative tables of different staffing
levels and experience levels and authority levels, and so forth that could be useful to the committee when the time comes to sit down and look at that.

MR. LIBBERTON: We have also done best practice as well as publish those kind of inventory and some of the things they do. That would be an input. And I wonder if perhaps by tomorrow could we, if not have physically could we kind of summarize inventory in terms of resources is that would be helpful to work on this.

MR. FLANIGON: Probably, maybe.

MR. LIBBERTON: Maybe not. Maybe we will get back to you.

MR. FLANIGON: At the point where the work group forms up we will have everything that we can put together, we will. And I think we very well might have a pre-summary of some things we can do to make that homework assignment for somebody.

Jackie.

MS. JETER: That is what I was going to
say, because I don't -- I think that the reason that this committee or this group was created was because it is not -- there is not a prevalent practice out there of having oversight committees or, you know, some type of regulatory body in each state that is going to do this.

So, we may be able to cherry pick from those who have it, you know, but I don't think that we are going to get some of the best -- you know, I going to refer to my colleague here from California. They happen to be on one of the better regulatory or oversight committees or whatever you want to call them, and they are there. And I think that is why they bring their expertise.

I think that we should cherry pick, but I don't think that spending a great deal of time trying to find that ideal agency, I don't think we are going do get it. I think we are going to have to create what we think they should do.

MR. FLANIGON: So, it's more of a
functional and what function should this ideal
capital agency daily perform.

    MS. JETER: Yes.

    MR. FLANIGON: I think Dave is next.

    MR. GENOVA: Just a couple of things.

One is I think one of the things on tomorrow's
agenda is the inputs, like the information that we
are going to review. And I think one of the
things that would be helpful in that process that
I didn't see listed there were the best practices
that have come out of the audit process of the
SSOs by the FTA. And then also, perhaps, those
audit reports.

And that way we would see which SSOs did
really well in the audits; which ones not so good.
But not so much to -- who is doing well and who is
not doing well, but to identify what the good --
what is working well and what is not working well.
I think that would be really helpful input into
the process.

    Also I noticed in the presentations
there was a lot of discussion about collaboration. And I don't know if anybody said that yet around the table, but for those SSO models that I think are working well, that we know about industry, there is a great deal of collaboration between the SSO and the transit agency.

And that was one of the questions on this relationship issue is, how should the SSO be in relationship to the FTA and then also in relationship to the transit agency. And I think the more collaboration we have built into that model, the more successful it will be, too.


MR. KRISAK: I was going to just suggest that based on a previous comment we heard earlier from your cochair, that we should extend that best practices beyond just state oversight in the U.S., but look at Asia and Europe. Look at those models and try to pick the best out of those as well. So, just expand the scope a little further.

And then the other comment I have,
having worked with a couple of different state
safety oversight issues, our agencies is kind of
what Georgetta was getting to. They comment on
things like punctuation and such, because that is
essentially where their level of knowledge is.
And unless they bring a strong consultant in to
help them out, most of them don't really
understand what they are looking at. So, they
approach it very much as a programmatic exercise
to satisfy the MTA, but in terms of in-depth
knowledge and expertise, they don't have it.

MR. FLANIGON: Rick.

MR. INCLIMA: Thank you, Mike. Just to
follow up on my last comment, because, you know,
it is a big undertaking in itself for us to come
up with this, because no one -- no one sees
everything -- perhaps, as I think about it,
perhaps the FTA is the only one that sees them
all.

And with that, would it make any sense
to the group, with all of the other data and
things we are going to look at, that perhaps FTA, you know, develop a, you know, strawman or a bullet list of what you think are important from -- you know, from where you sit and from what you see. That might be -- you know, that might help us cut to the chase. And then we could, you know, build upon that as a means to an end. Just a suggestion.

MR. FLANIGON: Thanks. That is a good thought. Eric.

MR. CHENG: I have two comments.

MR. FLANIGON: Mr. Vice Chairman.

MR. CHENG: I have two comments. First of all, I want to echo Harry's comments. I feel -- you know, each state is different, but maybe it would be a good idea for FTA to provide some expertise, experts, inspectors to help state. That means help. That is the first thing I want to say.

Secondly, is that I still, you know, the model we need to help to keep the flexibility. In
Utah we have discussed this kind of positions, you know, what kind of setup we want to use. We feel that we should have options to, you know, use the major (inaudible) of state of technical experts, but we should be able to allow to use consultant to help with things like that, because that is a long-term. We just use a dedicated person that affect the department, of course, internally. But that is how we feel.

MR. FLANIGON: Thanks. Other thoughts or comments?

MS. JETER: How long did you intend the question and answer to go on? I want to say something put I don't want to -- if you are trying the wrap up -- I'm trying to be gracious.

(Laughter.)

MR. FLANIGON: As the chairman of this robust committee, I am authorizing unlimited, unpaid over time.

(Laughter.)

MR. FLANIGON: So please.
MS. JETER: Eric actually mentioned consultant, and that is one of the things that was mentioned earlier. I don't know if getting into that direction is good, because if you get into the directions of hiring consultants, then don't you take away from the agency themselves policing their own safety and their own practices?

And, you know, I can only speak from my own experience at WMATA, and we brought Dupont in, one of the better ones. We brought them in 2 years before the accident, we still had the accident.

So, you get away from policing yourselves when you do that. And I think that as a group, I think we ought to steer clear of that. What we are trying to do is to get the agencies to do the work. And if we start talking about getting them ways out, I don't think they are going to do that.

MR. FLANIGON: That is a good thought. I think it speaks to building the internal
capacity, whether its is in the regulatory agency or the oversight agency, or the transit agency. And having that basic skill set in-house and able to work, I guess there is a balance, given the idea of scalability and, you know, the 2-mile streetcar line that can't afford to have the full range of technical expertise that the larger systems would.

So it I think it is a fruitful area for the work group that eventually gets stood up here, that we will be talking more about tomorrow to explore those kinds of options, those balances, and so forth. Tom.

MR. PRENDERGAST: Honestly, I think you kind of got to the point I was going to make, but I don't think I is either/or. I definitely agree that if we have people in the oversight capacity that don't have that the technical expertise to be able to understand whether or not the agency is doing what is required or not, that is going to be a loss, and that is going to hurt the ability of
the state oversight agency to effectively perform its oversight function.

On the other hand -- so, let's not throw the baby out with the bath water. I think you can bring in consultants with specific expertise that you need, but don't turn over the management and direction of those consultants. Have that management and direction still at a state level and the state makes the decision, because I think that is the best -- that can be a best of both worlds.

I have a metallurgist, because we buy so many cars and we do so much work on the design of a car truck, that I can afford actually two metallurgists. But if you are a smaller property, you are going to contract out for that resource. It is the same logic. So, I think is what we ought to look at in terms of how to find the best balance between those two.

MR. FLANIGON: Okay. I think Ed and then Bill.
MR. WATT: I think it might be more important to look in to see where these particular consultants have come from and if they have evolved, let's say. We just sat through several hours of presentation, as they talked about the industry has moved -- the safety industry has moved past looking at sharp end and the actual accident point. So I think we should, you know, keep that in mind and have the same types of best practices or instructions for the consultants that we would have for our internal auditing agency and right down the line. Otherwise, you contract out responsibility as well as contracting out the task, as I think Tom was talking about.

MR. FLANIGON: Thank you. Bill.

MR. GRIZARD: Thanks, Mike. The whole issue on, you know, what is fit for purpose I think needs -- you know, it needs some kind of performance base to it. But specifically on consultants, I think we are -- we are -- we need to look at a third party expertise. And it may
not be a consultant.

As Henry pointed out, and I think he is right, having a stable of technical experts on a national basis more as a quality control rather than anything else would be an important feature, and then to be able to loan them out to the states where they need that expertise would be an additional factor.

But there is also plenty of people in the industry that do have the expertise. And I know in California they draw upon their own folks from different levels. In rail, I think, you know, they have a track guy that is -- a couple of track specialists they can draw on and bring them into rail transit area and get comments from them.

The same thing is true from some of the other agencies. And APTA has been successful over the years with what they call peer reviews.

And so, you know, I wouldn't say that contracting is the only -- only answer here. And I would go back and take a look and say, okay,
what fits the purpose of what we are trying to
achieve, and then identify suitable options and
perhaps at some point there may be even a
certification course or something that the folks
that provide that type of service could be --
could at least show that they can achieve that
qualification level.

MR. FLANIGON: I think our discussion is
going in a very positive place, but I think it is
the place that the work group itself will start
flushing this sort of stuff out. And so I think
we have kind of already started some of the
people, and I would hope who have, based on those
comments, would want to be part of that work
group. Let's -- is that Georgetta? I have
trouble reading sideways.

MS. GREGORY: I like Bill's suggestion
about a collective pool of consultants maybe at
the federal level that the states could draw from.
I think that would -- we should make note of that.
That is a very good idea.
I would like to pose the thought that state safety oversight transit agency, whoever, when we become too reliant upon consultants, is that is not counterintuitive to the very safety culture we are proposing here?

There are some very good consultants out there, and they do have their place in the industry. But you know what, at the end of the day, they take their money and they are gone. And it is the people who are left working at the agency and for the states and for the feds that have to live with the product.

And I think that it is time that we do develop that curriculum to get the people trained and certified at the state level, because we are talking about the states here, rather than the total reliance upon the consultants to do that task.

I think the real issue, and hopefully this will come out in some of the data that you provide for the group, Mike is that there is such
a variance in the structure of the state oversight agencies. Most of them lie within the state Department of Transportations, there is a huge conflict of interest there, because the primary function of the DOT is to administer grants and it is sideline work for the state oversight manager. It is not their primary task.

So, they are not dedicated nor do they have the time to do that, and the certainly don't have the time to go to the properties and learn the business.

And, for instance, the consultant that I referred to earlier, the Georgia DOT has completely turned over the state safety oversight function to a consultant, and that is counterintuitive to our goal.


MS. DAVIDSON: Well, I had the advantage of having both the transit and the rail oversight authority. And you are correct, the transit side we had no expertise, nor did we have a structure
organized by disciplines; but on the rail side we did. And we drew on that.

Those folks had continuous training provided by FRA. And they could also draw on regional a pool of expertise at each regional agency.

I would submit that having that expertise reside at a regional level works very well. Maybe for -- if we could develop a sense of what disciplines most associate with passenger rail and then for the disciplines that require greater physical expertise and more difficulty to maintain and really keep someone busy at states where, say, the incline, historic incline at CARTA can't support something of that level, that then the states in that region could draw on that pool from the region.

And that would make it much more cost effective to provide that kind of service and not have to rely on consultants that -- I mean, they have a great role to play but, there is a lot of
turnover and movement within the consultant community that is sometimes disruptive.

MR. FLANIGON: Okay. Thanks. With that, I will make three announcements and we will conclude our work for the day.

First announcement is that you can leave your notebooks and so forth. The room is going to be locked up.

Second announcement, just a reminder that our -- we now have a reception starting in Room Number 5. Up one level and keep going that way.

And third announcement tomorrow being Friday and I'm California by birth and in the grand tradition of California, it is dress down Friday. So we can be business casual tomorrow for anybody who doesn't want to wear a tie female equivalent of a tie.

With that, thank you everybody and we will reconvene tomorrow morning at 8:00 o'clock, but 7:00 o'clock for coffee and conversation. We
got to get you up a little earlier tomorrow -- I'm sorry, 7:30 for coffee and so forth. 7:30 a.m., 8:00 o'clock start. Thank you.

(Whereupon, the meeting adjourned at 5:00 p.m.)
REPORTER'S CERTIFICATE

I, DONNA M. LEWIS, RPR, Certified Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth;

That the statements made at the time of the meeting were recorded stenographically by me and were thereafter transcribed;

That the statements are an reflection of the edits furnished by one or more of the participants after a transcription of my shorthand notes so taken to the best of my ability.

Dated this 21st day of September, 2010.

Donna M. Lewis, RPR