Transit Rail Advisory Committee for Safety (TRACS) Working Group 11-01 Report

Establishing a Confidential, Non-Punitive, Close Call Safety Reporting System for the Rail Transit Industry

*07/16/12*

### Table of Contents

[**FTA Administrator’s Tasking to TRACS Working Group 11-01 1**](#_Toc317106142)

[Introduction 2](#_Toc317106143)

[Principles and Characteristics of a Close Call Safety Reporting System 5](#_Toc317106144)

[Elements of Existing Systems 5](#_Toc317106145)

[Application to the Rail Transit Industry 9](#_Toc317106146)

[**Definition and Concept of Operations 11**](#_Toc317106147)

[Definition of a Close Call 11](#_Toc317106148)

[Concept of Operations 11](#_Toc317106149)

[Funding 14](#_Toc317106150)

[Special Considerations for Establishing a Pilot Close Call Safety Reporting System for the Rail Transit Industry 15](#_Toc317106151)

[Confidentiality 15](#_Toc317106152)

[Pilot Sites 16](#_Toc317106153)

 Criteria for Success: Pilot Program Evaluation…………..…………………………………………………………….............16

[Recommendations for Establishing a Confidential, Non-Punitive, Close Call Safety Reporting System for the Rail Transit Industry 18](#_Toc317106154)

[Appendix A: Examples of Unsafe Incidents That Could Qualify For Non-Punitive Safety Reporting in a Rail Transit Environment A-1](#_Toc317106155)

[Appendix B: Model Implementing Memorandum of Understanding for Establishment of a Confidential, Non-Punitive, Close Call Safety Reporting System for the Rail Transit Industry B-1](#_Toc317106156)

**Appendix C: Detailed Recommendations for Pilot Program Evaluation…………………………………………... C-1**

**Appendix D: Certificates of Confidentiality……………………………………………………………………………………....D-1**

# Acronyms

**ASAP** Aviation Safety Action Program

**ASRS** Aviation Safety Reporting System

**BTS** Bureau of Transportation Statistics

**C3RS** Confidential Close Call Reporting System

**CIPSEA**  Confidential Information Protection and Statistical Efficiency Act of 2002

**COC** Certificate of Confidentiality

**ERC** Event Review Committee

**FAA** Federal Aviation Administration

**FOIA** Freedom of Information Act

**FRA** Federal Railroad Administration

**FTA** Federal Transit Administration

**MOU** Memorandum of Understanding

**NASA** National Aeronautics and Space Administration

**NJT**  New Jersey Transit

**NIH** National Institutes of Health

**PII** Personally Identifiable Information

**PRT** Peer Review Team

**RTA** Rail Transit Agency

**SSO** State Safety Oversight

**TRACS** Transit Rail Advisory Committee for Safety

# FTA Administrator’s Tasking to TRACS Working Group 11-01

“TRACS recommended that FTA pilot a close call, non-punitive reporting system. TRACS determined that FTA can improve the collection and analysis of vital safety data and trends by supporting the development of such a system. TRACS is tasked with providing consensus advice to FTA on proposed models and strategies for transit systems to implement a voluntary non-punitive reporting system that comports with its recommendation.”

Peter Rogoff, FTA Administrator, Memo to TRACS Working Group 11-01, 4/28/2011

#

# Introduction

## Purpose of a Close Call Safety Reporting System

The primary purpose of a close call safety reporting system is to improve overall safety by encouraging employees to report unsafe conditions or acts voluntarily that would otherwise not be known or detected by transit agency management.

A close call reporting system offers another tool to identify and assess safety risks in transit agency operations. Close call reporting systems present opportunities to improve a transit agency’s safety performance by producing safety-critical information that can lead to strategies and interventions to prevent accidents and injuries. To be effective, all parties must work together to improve safety, and the system must make all participants feel comfortable reporting their concerns without fear of potential discipline, reprisal, dismissal, or legal discovery.

A close call reporting system at its best is an opportunity for employees and management to collaborate in achieving a higher goal – safety. An accident or an injury affects everyone, so it is essential that employees and management work together toward building a system of non-punitive close call reporting.

## Confidential, Non-Punitive, Close Call Safety Reporting

The rail transit industry can benefit greatly from lessons learned by other transportation modes, which have initiated confidential, non-punitive, close call safety reporting systems. These voluntary systems encourage all employees to report events (i.e., noteworthy happenings that adversely affect safety or have the potential to adversely affect safety) that otherwise would not have been discovered by transit agency management yet nonetheless could be symptoms of problems that could lead to more serious future events. These systems also encourage the reporting of general safety concerns, even if they have not yet resulted in an identified “event.” Through systematic report analysis, accident precursors that might otherwise have gone undetected or undocumented are identified, and corrective measures can be taken to eliminate or control their causes.

It is not unusual to find an organizational culture in the rail transit industry where employees perceive that events are blamed on the actions or inactions of individuals, without in-depth investigation into the possible underlying systematic issues. Thus, employees may rightly fear disciplinary action or some other form of reprisal from a rail transit agency (RTA) for reporting a close call event, thus creating a strong disincentive for individuals to report close calls or other potential safety concerns. This lack of trust between front-line employees and their supervisors and management often leads to essential information going unreported.

This report will show that in existing confidential, non-punitive, close call safety reporting systems, employees and management can work collaboratively by implementing a memorandum of understanding (MOU). A properly structured MOU can provide the framework for facilitating a just safety culture that leads to safety improvements. The following statements illustrate the concept of a just safety culture:

“Getting people to report is about building trust: trust that the information provided in good faith will not be used against those who reported it. Such trust must be built in various ways. An important way is by structural (legal) arrangement. Making sure people have knowledge about the organizational and legal arrangements surrounding reporting is very important: disinclination to report is often related more to uncertainty about what *can* happen with a report, than by any real fear about what *will* happen.” (Dekker, S.W.A. (2007). *Just Culture: Balancing Safety and Accountability.* Lund University, Sweden, Ashgate Publishing Co. pp. 43-44).

“If an organization wants to encourage reporting, it may actually have to curtail disclosure. Reporters will step forward with information about honest mistakes only when they feel they have adequate protection against that information being misused or used against them. This can mean that reported information must somehow remain confidential, which rules out disclosures (at least of that exact information).” (Ibid., p. 48)

We find that there is strong potential for a confidential, non-punitive, close call safety reporting system to build trust between labor and management and to help establish a just safety culture throughout a rail transit enterprise. Establishing a robust safety culture where all stakeholders work together to continually improve safety is the ultimate goal of a confidential, non-punitive, close call safety reporting system.

Existing Federal safety regulation of the rail transit industry is primarily enforced through state safety oversight organizations (SSO), which are controlled at the State level. For the rail transit mode, each SSO is responsible for overseeing safety within its State, which results in varying degrees of enforcement and sophistication. While we find that the SSO role is important and necessary, we also find that the current structure and authority of many SSOs does not sufficiently provide the resources needed for establishing and maintaining a confidential, non-punitive close call safety reporting system.

Existing similar reporting systems employ a non-regulatory, independent third-party agency, representing the specific transportation mode on a national scale, to provide the assurances of confidentiality to reporting employees. Likewise, this report proposes that an independent third party administer a confidential, non-punitive, close call safety reporting system, which would operate in partnership with the RTAs, the Federal Transit Administration (FTA), and potentially SSOs, and which would disseminate data and analysis on identified patterns and trends throughout the rail transit industry, as appropriate. Ideally, there would be one third-party administrator to ensure consistency and comparability of data across transit systems; however, if more than one third-party administrator is used, it would be important to assure that independent third-party administrators compile data uniformly to allow for the aggregation of national datasets and trends. We recommend that FTA lead this effort in cooperation with one or more third-party administrator(s), to develop such a uniform format for aggregating data.

This report presents our findings on the principles and characteristics of existing reporting models used by the Federal Aviation Administration (FAA) and the Federal Railroad Administration (FRA) for reporting, analyzing, and responding to reports of safety events and concerns, summarized in Table 1. Next, this report provides a concept of operations for adapting existing models to the rail transit industry. We present several issues for further consideration related to establishing a pilot system, and finally, we present our recommendations on how FTA can support the establishment of a confidential, non-punitive, close call safety reporting system for the rail transit industry.

#

# Principles and Characteristics of a Confidential, Non-Punitive, Close Call Safety Reporting System

## Elements of Existing Systems

Existing models of close call safety reporting systems used by the Aviation Safety Action Program (ASAP), FAA/NASA Aviation Safety Reporting System (ASRS), the FRA/BTS pilot system (C3RS/BTS), and the FRA/NASA pilot system (C3RS/NASA).

Table : Elements of Existing Close Call Safety Reporting Systems

| **Element** | **Description** | **ASAP** | **ASRS** | **C3RS/NASA** | **C3RS/BTS** |
| --- | --- | --- | --- | --- | --- |
| **Voluntary Reporting** | Rely on employees to voluntarily report safety incidents and concerns. | Reports submitted to an Event Review Committee (ERC) composed of representatives from FAA, management, and labor.  | Reports submitted to an independent third-party agency. | Reports submitted to an independent, third-party agency. | Reports submitted to an independent, third-party agency. |
| **Confidential Reporting** | Take care in ensuring that identities of reporting individuals cannot be disclosed; some protect the identity of the carrier.  | Personally identifiable information (PII) is not destroyed; reports are not protected from legal disclosure. | PII is removed once the report has been processed, coded, and stored in a database. | PII is removed once the report has been processed, coded, and stored in a database.  | PII is not destroyed, but carefully protected under the Confidential Information Protection and Statistical Efficiency Act (CIPSEA), Title V of the E-Government Act of 2002. |
| **Non-Punitive** | Close call safety reporting systems provide protection from disciplinary action for employees that submit a qualifying report, which encourages individuals to voluntarily report safety close calls. In some cases, the carrier is protected from regulatory discipline as well. | Employees who submit qualifying reports receive a corrective action letter in lieu of civil penalty action. | Employees who submit qualifying reports are protected from disciplinary action. | Employees who submit qualifying reports are protected from disciplinary action. The carrier is protected from FRA enforcement action as well. | Employees who submit qualifying reports are protected from disciplinary action. The carrier is protected from FRA enforcement action as well. |
| **Third-Party Data Collection and De-identification** | To ensure confidentiality, most but not all, close call safety reporting systems employ a third-party agency to receive, process, and, in some cases, investigate the reports.  | An independent third-party agency is not employed. Reports are analyzed by the ERC. Currently 166 of these programs send duplicate data to the NASA ASRS system. | NASA is the third-party agency for ASRS. NASA receives and processes the reports and follows up with phone calls when necessary to clarify details. Reports are coded and entered into the system for later analysis. | NASA is the third-party agency. NASA receives the reports directly and conducts a thorough analysis that includes an in depth callback using industry experts. NASA compiles event reports that are forwarded to the corresponding PRT after de-identification. NASA retains aggregated de-identified coded data. | BTS is the third-party agency. BTS receives the reports directly and conducts in-depth follow-up interviews with employees who submit reports using industry experts. BTS compiles composite reports on close call events that are forwarded to a Peer Review Team (PRT) at the FRA pilot site for further analysis. BTS retains all information, including PII. |
| **Analysis and Feedback** | Analyses performed by close call safety reporting systems vary and therefore the systems provide different feedback. | ERCs analyze individual reports, identify actual or potential problems, and propose solutions for those problems. | NASA performs analysis to identify deficiencies and discrepancies in aviation systems that are reported to the stakeholders of the aviation industry at-large. All PII or carrier identification is removed. Aggregated, de-identified reports are available to all stakeholders and the general public on the ASRS website. | Analysis initially performed by NASA through data coding protocols. Data are sent to PRTs housed at the individual railroads where they are further analyzed. PRTs consist of representatives from management, labor, and the FRA, including front-line employees. PRTs perform root-cause analysis of each reported incident and make recommendations to management for corrective action. PRTs can also conduct carrier-level analysis of reports to identify patterns and trends. | FRA’s system uses PRTs housed at railroads to analyze reports. PRTs consist of representatives from management, labor, and the FRA, including front-line employees. PRTs perform root-cause analysis of each reported incident and make recommendations to management for corrective action. PRTs can also conduct carrier-level analysis of reports to identify patterns and trends. In addition, C3RS analyzes and reports on agency and industry trends. |
| **Stakeholder Involvement and Empower-ment** | All four systems have actively engaged all industry stakeholders in the process. The confidential nature of the reporting systems gives equal priority to reports made by any individual, regardless of position within an organization.  | All employees covered under the implementing MOU can report safety concerns. All reports are given equal weight. The ERC structure involves multiple stakeholders in the analysis of reports. | Anyone involved with safety-critical operations can report safety concerns. All reports are given equal weight.Results are reported industry-wide through alert bulletins, newsletters, teleconferences, and participation in industry and government forums. | Any employee covered under the implementing MOU can report safety concerns without fear of retaliation or discipline. All reports are given equal weight. PRT structure involves all stakeholders in the analysis of reports, empowering those involved to put their unique perspectives and experience to work improving safety conditions. Trends are not reported beyond the individual railroad in most cases. | Any employee covered under the implementing MOU can report safety concerns without fear of retaliation or discipline. All reports are given equal weight. PRT structure involves all stakeholders in the analysis of reports, empowering those involved to put their unique perspectives and experience to work improving safety conditions. Trends are not reported beyond the individual railroad in most cases. |

### Application to the Rail Transit Industry

The working group finds that the C3RS confidential, non-punitive, close call safety reporting system model used by FRA is well suited for adaptation to the rail transit industry. We agree with the general system elements outlined in Table 1, and support the general concept of event analysis by Peer Review Teams (PRTs) with appropriate stakeholder representation housed at the RTA level. However, significant differences exist between FRA-regulated railroads and RTAs that will need to be addressed in the structure of an FTA confidential, non-punitive, close call safety reporting pilot.

#### Key Issues

* Writing and establishing an implementing MOU is a critical step in creating a confidential, non-punitive, close call safety reporting system (see Appendix B for a model MOU).
	+ The implementing MOU sets the terms by which various stakeholders and agencies will participate in the reporting system. Therefore, it must address all reasonable situations that employees are likely to experience, including what is and is not reportable, and what conditions must be met to qualify for protection from disciplinary action.
	+ The implementing MOU also indicates which RTA employees can participate in the system. Some FRA pilot sites chose not to include some employees due to the limited spatial scope of the pilot (e.g., does not cover mainline track), employees being based distant from pilot sites, or other practical considerations. However, most of these concerns are unlikely to be barriers to inclusion for RTAs. Therefore, whenever feasible, the implementing MOU should include all employees and contractors of the RTA.
	+ While forming the implementing MOU, stakeholders must consider how the presence of passengers and the rising use of technology to detect incidents can create challenges for the system. To the extent that events are known in real time through monitoring or alarm devices, fewer events will be reportable unless provision is made to support some known events.

Example: When the FRA pilot was expanded to include New Jersey Transit (NJT), events that involved the safety of passengers, such as doors opening on the wrong side or a missed station platform, were not sufficiently addressed in the implementing MOU, thus they were not considered qualifying incidents for the close call safety reporting system. Nevertheless, the NJT pilot stakeholders determined that they would include these types of events under certain conditions, even though they were known to the agency.

* Any close call safety reporting system for the rail transit industry must include strong assurances of confidentiality for any data, reports, or other information created by the system. Employees must be assured that personally identifiable information (PII) in reports will not be disclosed by the third-party agency and RTAs must be assured that reports, analyses, and trend data are protected from disclosure requirements of the Freedom of Information Act (FOIA), relevant State statues, and legal discovery.
* Protection from discipline for qualifying events identified in the implementing MOU should be afforded to all parties who are signatories of the implementing MOU. Labor unions must be included to ensure that the reporting employees are protected from discipline by the RTA. The implementing MOU should also include mechanisms to protect employees that submit reports from retaliation, dismissal, and other forms of discrimination by both supervisors and peers. Including SSOs as implementing MOU signatories could potentially allow SSO staff to participate in PRTs while ensuring that RTAs are protected from regulatory action based on information learned through the PRTs.
* Relative to the railroads engaged in the C3RS pilot reporting systems, rail transit systems have widely varying track and equipment from agency to agency. Unique characteristics of any RTA’s systems may make de-identification of reports more difficult than in the C3RS system.
	+ Examples:
		- Older systems have switch structures that are no longer in production and are relatively rare.
		- Light-rail vehicles, historical rail vehicles, and other systems used by some RTAs are distinctive and unique (such as San Francisco’s cable cars). This may make de-identification so difficult as to discourage reporting.

## Definition and Concept of Operations

### Definition of a Close Call

The rail transit industry embodies many diverse characteristics: system age, infrastructure, technology, and management structures. Therefore, stakeholders of each individual RTA must define the events that do and do not qualify for close call safety reporting. The implementing MOU should clearly define and provide specific examples of qualifying events and should also identify timeframes for reporting, to include extenuating circumstances that would disqualify an event from the close call safety reporting system.

As a starting point, we present the following working definition:

A **close call** is a situation or circumstance that had the potential for safety consequences, but did not result in an adverse safety event. Knowledge about a close call presents an opportunity to improve safety practices and culture. Events that do and do not qualify for close call safety reporting must be defined by the stakeholders of each individual RTA’s implementing MOU**.**

See Appendix A for examples of situations that could be considered close calls.

### Concept of Operations

A concept of operations for a pilot, confidential, non-punitive, close call safety reporting system for the rail transit industry is illustrated in Figure 1. This concept closely conforms with the structure of the existing C3RS system used by FRA pilots, with NASA and BTS as third-party agencies. Descriptions of each phase follow.

Figure : Concept of Operations for a Confidential, Non-Punitive, Close Call Safety Reporting System

Individual agencies, labor unions, and other participating stakeholders work collaboratively to develop and sign an implementing MOU with a third-party agency, FTA, and SSO(s) (when applicable). The implementing MOU includes specific details of program operations, including reporting mechanism(s) and timeframe, confidentiality protection procedures, composition of the PRT, definitions of qualifying and non-qualifying reports, conditions for reporting of trend data, and funding of the third-party agency.

**Note:** Existing C3RS implementing MOUs could be used as a quasi-boilerplate or starting point. Appendix B of this report provides a model MOU, adapted from a C3RS implementing MOU, which could be used for this purpose. However, all parties should be actively engaged in reviewing and modifying the implementing MOU to identify unique issues that should be addressed and facilitate buy-in from all stakeholders.

Employees can voluntarily report an incident or concern directly to the designated third-party agency following the procedures detailed in the implementing MOU (e.g., phone call, paper, or electronic submission). All reports are kept confidential; the identity of the individual submitting the report is never revealed beyond the third-party agency. Employees receive protection from disciplinary action when they report qualifying events.

The third-party agency determines if the report meets the requirements of the implementing MOU and follows up with the reporting employee, informing him or her whether the report was accepted as a qualifying report. If it is not accepted under the terms of the implementing MOU, the reporting employee receives an explanation from the third-party agency as to why it did not qualify and the report is destroyed. In either instance, the reporting employee’s confidentiality is maintained.

Reporting employees receive a receipt once the third-party agency has approved the report as being within the scope of the system as documented in the implementing MOU. This receipt provides documentation of the reporting employee’s protection from discipline from the RTA.

For all qualifying reports, subject-matter experts at the third-party agency conduct follow-up interviews to gather more information about reported events, synthesize all available information, and send event reports to the PRT for review, with PII removed.

Each pilot site forms a PRT consisting of RTA management, labor, FTA, and, in some cases, SSO stakeholders, which reviews each event report forwarded by the third-party agency. PRT members receive thorough training in event root-cause analysis before joining the PRT. PRTs can prioritize event reports by severity and/or frequency of occurrence of the perceived safety threat, addressing the most urgent issues first. For each event report, the PRT performs a systematic analysis and makes recommendations for corrective action to a higher-level RTA management support team, or less commonly to the FTA or SSO, as appropriate.

A high-level RTA management support team evaluates corrective action recommendations and determines agency response. The FTA or SSO could also implement corrective actions in some cases. Any action taken as a result of a close call report is shared with all PRT members. In turn, the PRT shares these actions with the third-party agency to facilitate tracking, analysis, and reporting of industry-wide trends and best practices.

PRTs provide feedback to the third-party agency describing the nature of the problem and recommendations for resolving the reported events. PRT responses are tracked and reported to FTA and the applicable SSO. All reports and corrective actions are kept confidential, but FTA shares aggregated trends, lessons-learned, and best practices among all industry RTAs and SSOs. The third-party agency and RTA widely publicize all actions taken as a result of a close call report.

### Funding

Ideally, funding for establishing and operating a third-party agency should be provided by FTA. It is expected that rail transit agencies would provide personnel time, facilities, and materials for establishing and operating the PRTs. It is also expected that RTAs participating in the pilot program will dedicate funding to implement the corrective actions recommended by the PRTs.

# Special Considerations for Establishing a Pilot, Non-Punitive, Close Call Safety Reporting System for the Rail Transit Industry

### Confidentiality

The absolute assurance of confidentiality is of paramount importance for the success of a non-punitive, close call safety reporting system. Even one breach of confidentiality will ruin a fledgling reporting system. Thus, sufficient care should be taken to establish the proper legal basis for the maximum protection of the pilot system’s confidential data. The C3RS pilots use two different mechanisms to protect confidential information. Some pilots rely on the statutory authority provided to statistical agencies under the Confidential Information Protection and Statistical Efficiency Act (CIPSEA). Others rely on strict administrative controls and procedures that require permanent removal of PII from all reports once they have been processed and coded.

The TRACS Working Group recommends that FTA conduct a legal analysis to ensure that the following confidentiality protections are provided as part of any pilot, non-punitive, close call safety reporting system for the rail transit industry. FTA should explore all existing confidentiality protection options that meet these criteria.[[1]](#footnote-1) The working group also recommends that FTA pursue new legislation that would give FTA the authority to ensure the confidentiality of safety information obtained from safety reporting systems.

* Raw data, such as individual reports containing PII, must be protected from disclosure beyond the third-party agency and PRT members.
* The assurance of confidentiality must extend to the RTAs, and offer exemption from disclosure under the FOIA, relevant State statutes, and legal discovery of information related to close call events.
* To minimize the risk of disclosure, PII should be permanently removed from reports once analysis and follow-up are complete.
* If trend data are to be collected, the third-party agency should strip the data of any identifying features about any individual RTA. All pilot system participants should receive thorough training on the protections against disclosure that the system provides.
* PRT members must agree to a strict prohibition from disclosing any confidential information they learn of through participation in the PRT.

### Pilot Sites

Large transit agencies that are currently developing close call safety reporting systems of their own may be the best initial candidates for a FTA pilot close call safety reporting system because they tend to have more resources. However, it is important to consider the diverse nature of the rail transit industry when selecting sites for such a pilot. Selecting sites from among large, medium, and small RTAs may allow for the practical differences between RTAs that a national system would need to evaluate.

* Select pilot sites where all stakeholders (e.g., RTA management and supervisors, labor unions, SSO) are committed to the project to maximize success.
* Select three to six sites that FTA believes have sufficient interest, resources, and commitment, and expand to additional sites if the pilots are deemed by FTA to be successful.
* Avoid agencies with strained labor and management relationships as pilot sites as tensions will make the trust-building period more difficult, thus increasing chances of failure.

### Criteria for Success: Pilot Program Evaluation

The pilot program should be evaluated for two primary reasons:

1. To ensure that the pilot program is successful in producing value to the safety of rail transit systems; and
2. To identify areas of needed improvement and resources for implementation beyond the pilot sites.

In this regard, the working group makes the following recommendations, with greater detail in Appendix C.[[2]](#footnote-2) In summary, the evaluation primarily should determine if the pilot was successful in its goal to produce hazard identifications that otherwise would not have been identified and mitigated.

The evaluation of the pilot would include:

* **Logic model.** The model would describe and illustrate program theory, identify program components and how they were causally connected, and thus how the outcomes are produced.
* **Inputs.** The evaluation should document the resources that were available and used.
* **Outputs: Implementation activities, benchmarks, and indicators.** The evaluation should document the components put into practice for the pilot projects.
* **Outputs: Descriptive statistics.** Data would document the implementation in terms of time spent, volume of close call reports filed, volume of follow-up reports issued, etc.
* **Primary substantive outcomes.** These are the most important criteria and should inform decisions about future rollouts. Did the pilot result in new, useful information that was acted upon to benefit safety that would not have been available otherwise? Actual safety performance trends should also be tracked, but due to normal variation and measurement difficulties from factors beyond the context and control of the pilot projects, these data may not reveal much about the pilot programs’ success.
* **Other substantive outcomes: Organizational benefits, program diagnostics.** These may be considered secondary, but are still important substantive goals. Benefits to safety culture in general, such as measures of attitudes, perceptions, trust, justice, empowerment, self-efficacy in safety, job satisfaction, and organizational citizenship behavior should be examined for general findings, and also to identify areas needing attention.
* **Meta-evaluation.** A retrospective “evaluation of the evaluation” should be performed to assess how well the evaluation provided the desired information.

#

# Recommendations for Establishing a Confidential, Non-Punitive, Close Call Safety Reporting System for the Rail Transit Industry[[3]](#footnote-3)

1. FTA should support the establishment of a confidential, non-punitive, close call safety reporting system by forming an implementation work group comprised of stakeholder representatives tasked with establishing a pilot system.
2. FTA should establish a pilot system and perform the following:
	1. Negotiate an implementing MOU between labor, management, FTA, an independent third-party agency, and SSOs as necessary, at three to six transit agencies.
	2. Provide assurances that the close call safety reporting system will be voluntary, non-punitive and confidential, and provide protection from FOIA, State public records laws, and legal discovery for all participating stakeholders.
	3. Recruit and fund a non-biased third party to manage the pilot reporting system and assign the roles of system liaison and support staff.
	4. Identify or develop data collection and analysis software and methodology.
	5. Assemble a PRT at each pilot site.
	6. Provide PRT members with appropriate training in hazard analysis prior to rollout of the pilots.
	7. Implement the pilot system at three to six transit agencies for a minimum of 3 years.
	8. Refine report taxonomy based on initial reports.
	9. Develop criteria and outcome measures for the pilot program.
	10. Evaluate pilot success by independent review (ensuring the reviewer has confidential and appropriate access to the data).
	11. At least annually, FTA should prepare and distribute a report containing de-identified trend data observed at pilot sites to stakeholders throughout the rail transit industry, including RTAs, labor, and equipment manufacturers. The trend data should include the types of incidents being reported and the measures taken by RTAs to correct reported incidents. FTA should also request this information from any RTAs which have established independent close call safety reporting systems which are not participants in the pilot system, for inclusion in these reports.
3. Each pilot program should develop a communications plan to disseminate analysis results and management follow-up actions between all signatories of the implementing MOU.
	1. Provide timely follow-up to reporting employees.
	2. Conduct analyses of reports and distribute to management and employees.
	3. Issue newsletters on a periodic basis for employees at the pilot sites informing them of the progress and status of the reporting system.
	4. Use reports as tools for training.
4. At the conclusion of the pilot, FTA should publish a final report describing the outcome of the pilot. If the pilot is deemed successful, FTA should establish a national confidential, non-punitive, close call safety reporting system that is available for voluntary participation by all RTAs. As part of this national program, FTA should:
	1. Evaluate the feasibility of establishing a single, national, third-party agency for a national close call safety reporting system.
	2. Negotiate an implementing MOU between labor, management, FTA, an independent third-party agency, and SSOs as necessary, for all new participants.
	3. Provide implementation assistance to new participants.
	4. Disseminate the results of the national, close call safety reporting system to stakeholders on an annual basis.
	5. Provide ongoing training regarding the importance of the close call safety reporting system.
	6. Develop and publish guidelines for independent, confidential, non-punitive close call reporting systems established by RTAs or SSOs that elect not to join a national system. These guidelines should include a standard reporting mechanism such that data from these systems can contribute to industry-wide patterns and trends analyses.
5. FTA should pursue legislation that would provide it with statutory authority to protect confidential safety information obtained from close call safety reporting systems.

#

# Appendix A: Examples of Unsafe Events That Could Qualify For Confidential, Non-Punitive, Close Call Safety Reporting in a Rail Transit Environment

1. Doors opening on the wrong side
2. Overshooting or bypassing a station
3. Split switch incidents
4. Signal run-through incidents
5. Doors opening when train is not properly berthed
6. Running through any required stop
7. Speeding
8. Improper flagging
9. Failing to blow the horn when required
10. Going through a grade crossing with broken gates without stopping
11. Operating on the wrong track
12. Operating beyond authorized limits
13. Failure to protect adjacent track when necessary for safety
14. Non-compliance with wayside rail transit worker protection rules
15. Third rail or OCS power-related incidents

#

# Appendix B: Model Memorandum of Understanding for Establishment of a Confidential, Non-Punitive, Close Call Safety Reporting System for the Rail Transit Industry

Table of Contents

[1.Purpose of the Model Memorandum of Understanding B-2](#_Toc317106158)

[2.Background B-2](#_Toc317106159)

[3.Purpose of the Confidential Close Call Safety Reporting System B-3](#_Toc317106160)

[4.Scope of the Close Call Safety Reporting System Pilot Project B-4](#_Toc317106162)

[5.Close Call Safety Reporting System Pilot Project Description B-4](#_Toc317106163)

[6.Eligibility B-7](#_Toc317106167)

[7.Reporting Procedures B-7](#_Toc317106168)

[8.Confidentiality B-8](#_Toc317106172)

[9.Protection from RTA Discipline and FTA/SSO Enforcement B-9](#_Toc317106173)

[10.Use of Data B-11](#_Toc317106178)

[11.Corrective Actions B-11](#_Toc317106179)

[12.Stakeholders’ Responsibilities in Support of the MOU B-11](#_Toc317106180)

[13.Modifications B-18](#_Toc317106186)

[14.Project Duration B-18](#_Toc317106187)

[15.Record Keeping B-19](#_Toc317106188)

[16.Funding B-19](#_Toc317106189)

[17.Responsible Officials B-19](#_Toc317106190)

[18.Cooperating Organization Signatures B-19](#_Toc317106191)

# Purpose of the Model Memorandum of Understanding

The U.S. Federal Transit Administration (FTA) and the transit industry share an interest in improving railroad safety. As part of its mission, FTA is sponsoring the Confidential, Non-Punitive, Close Call Safety Reporting System pilot project to demonstrate the effectiveness of a confidential, non-punitive close call reporting system for the rail transit industry. This system will capture data that would otherwise not be captured as well as provide rail transit agencies (RTA) and FTA with opportunities to identify safety issues that require corrective action.

This model Memorandum of Understanding (MOU) describes the preferred provisions of the close call pilot project and explains the rights, roles, and responsibilities of the participants under the project. It describes the ideal system of how a confidential, non-punitive, close call safety reporting system should be implemented. However, due to the differences between transit systems, this model MOU should be reviewed thoroughly and adapted as necessary.

The purpose of this MOU is to gain full agreement from all parties to cooperate in the close call pilot project. Actual implementation of the project, involving particular transit agencies, one or more of their labor organizations and when appropriate, state safety oversight (SSO), will be achieved through separate implementing memorandums of agreement (implementing MOUs) approved by FTA, as specified in section 12. The implementing MOUs will incorporate the various rights and responsibilities set out in this MOU, modified to meet the unique needs and circumstances of the implementing MOU stakeholders. They will also contain additional provisions tailored to the needs of the participating parties, including how an RTA that is contemplating disciplinary action against one of its employees is notified that the employee is protected from such action under the implementing MOU.

# Background

Over the last decade, the transit industry achieved significant progress in improving the safety of transit agency operations. Current transit agency safety programs focus on collecting data primarily on reportable accidents. However, as the number of reportable events declines, accident data become less valuable in determining the sources of risk. Also, when safe outcomes do occur, there is nothing to capture the organization’s attention: safety is invisible.

Nearly all transportation incidents are preceded by a chain of events or circumstances, any one of which might have prevented the accident if it had gone another way. In many cases, operators are aware of these “close calls,” and may have information that could prevent future mishaps. For example, the National Transportation Safety Board (NTSB) report of the collision and derailment of Maryland Rail Commuter (MARC) Train 286 and National Railroad Passenger Corporation (Amtrak) train 29 near Silver Spring, MD on February 16, 1996, cites several related close calls that preceded the crash.[[4]](#footnote-4)

Transit agencies can reduce risks before an accident by analyzing close calls. When individual close call events are analyzed collectively, transit agencies can identify safety hazards and develop solutions to these threats. Close call reports can also provide important safety information to FTA thereby enabling FTA and SSOs to more effectively perform their oversight role.

Transit agency employees, like employees in other industries, are often unwilling to report observed events that could result in adverse safety outcomes particularly with respect to self-reported behaviors, because disclosure may result in punishment for the employee. Confidential, non-punitive, close call safety reporting systems address these problems by collecting information about close calls in a way that protects the employee’s identity.

# Purpose of the Confidential Close Call Safety Reporting System

A confidential close call reporting system is not separate and apart from the existing transit agency reporting systems. It provides another tool to identify and assess safety risks in transit agency operations. Close call reporting systems present opportunities to improve a transit agency’s safety performance by producing safety-critical information that can lead to strategies and interventions to prevent accidents and injuries. The system can also be used to monitor changes in safety over time and to uncover hidden unsafe conditions that were previously unreported.

For this pilot project, close call reports should address the following four goals:

1. Monitor the frequency of known failure modes (existing risks to safety);
2. Learn about new failure modes (new risks to safety);
3. Heighten awareness of safety risks in transit agency operations; and
4. Enable RTAs, labor organizations, and SSOs to identify safety issues that require corrective action.

The Confidential, Non-Punitive, Close Call Safety Reporting System Pilot Project should foster a voluntary, cooperative, non-punitive environment to communicate safety concerns. Through analysis of close calls, the parties implementing MOUs and FTA will receive information about factors that may contribute to unsafe events and the error recovery mechanisms that prevented an adverse consequence from occurring. Participating RTAs can use this information to help them develop corrective actions to help reduce risks to safety. The close call safety reporting system should also track and assess the corrective actions taken in response to close call events to identify successful and unsuccessful actions. The program should help determine what factors (i.e., equipment design, training, operating practices, management practices) promote the elimination of errors and what factors promote recovery from errors. FTA can use the information to perform its transit agency safety oversight role, including disseminating important safety information to other RTAs and developing safety and enforcement tools to address widespread safety problems.

## Definition of “Close Call”

A **close call** is a situation or circumstance that had the potential for safety consequences, but did not result in an adverse safety event. Knowledge about a close call presents an opportunity to improve safety practices and culture. The events that do and do not qualify for close call safety reporting must be defined by the stakeholders of each individual RTA’s implementing MOU**.**

# Scope of the Confidential, Non-Punitive, Close Call Safety Reporting System Pilot Project

The Close Call Pilot Project applies to RTAs and their employees who are included in written implementing MOUs that have been approved by FTA in accordance with section 12. Whenever feasible, all employees and contractors of an RTA should be included in the implementing MOU. It is expected that the pilot project would need to be operational for three years before quantitative outcomes can be measured. (See section 14 for a discussion of the duration of the project.)

# Close Call Safety Reporting System Pilot Project Description

FTA is sponsoring the Close Call Safety Reporting System Pilot Project to demonstrate the effectiveness of a confidential close call safety reporting system to improve transit agency safety.[[5]](#footnote-5)

The project is designed to perform six primary functions:

1. Accept reports of close calls that meet the criteria set forth in section 7.1;
2. Store confidential data;
3. Analyze close calls;
4. Disseminate reports on trends and other information for use by participating parties and FTA;
5. Track RTAs’ reports on their corrective actions to measure the system’s impact on safety; and
6. Evaluate and identify ways to improve the effectiveness of the reporting system.

The system will be a dynamic pilot project. The project should identify the elements needed to foster a successful outcome and the project will be adjusted as needed to ensure it continues to meet program objectives and the needs of the industry.

To provide confidentiality for individuals who report close calls, a third party is needed to accept, store, process, and analyze the reports, as well as to disseminate reports to the participants and FTA on trends and new risks. FTA would enter into a separate memorandum of agreement with the identified third party under which funding for project administration would be provided. The third party will likely hire a contractor with expertise in transit agency technology and operations. The contractor will receive additional training from the third party in the functioning of the close call safety reporting system. Training will be standardized to ensure consistent operation of the system.

## Key elements of the Close Call Safety Reporting System

The close call safety reporting system adheres to the following key elements:

1. Focused on identifying risks to transit agency safety;
2. Voluntary;
3. Confidential; and
4. Provides participating employees with protection from discipline by the employer in specified reporting situations.

## Key Stakeholders

The primary organizations that will be involved in the pilot project are: FTA Office of Safety; the third party; an independent organization to conduct program evaluation; the RTAs; the labor organizations; the relevant SSO; and the Peer Review Team (PRT), an expert team comprised of the key stakeholder representatives from the RTAs, representatives from relevant labor organizations, and in some cases, SSOs.

## Steps in the reporting process

| **Step** | **Responsible party** |
| --- | --- |
| 1. Identify an unsafe event or condition and initiate a close call report.
 | Employee(s)  |
| 1. Enter close call report in tracking system if it meets preliminary acceptance criteria.[[6]](#footnote-6)
2. Confirm eligibility (see section 7.1, criteria for close call report acceptance).
3. Date stamp and assign number.
4. Mail receipt to employee.
5. Provide feedback to reporting employee(s) if report is rejected. Destroy non-qualifying reports.
 | Third party/ Contractor |
| 1. Interviewer calls employee(s) to collect additional details about close call event or unsafe condition. If it meets acceptance criteria, report receives final acceptance.
 | Third party / Contractor |
| 1. De-identify close call report.
 | Third party / Contractor |
| 1. Analyze individual close call report for preliminary root causes and error recovery mechanisms. Analyze multiple reports for emerging trends and new sources of risk. Produce a report based on the collected data and forward to the PRT for analysis.
 | Third party / Contractor |
| 1. Meet at regular intervals to:
2. Analyze each close call report (after identifying information has been removed) and root causes;
3. Analyze summarized data from multiple reports;
4. Identify new sources of emerging trends and new types of safety-critical risks;
5. Assess the association between emerging patterns or trends in close calls, relate those to corrective actions to be taken by the RTAs, and advise on implementation;
6. Review and discuss a summary report comprised of the individual close call reports generated from the Close Call Safety Reporting System, emerging trends, identified root causes, and suggested corrective actions;
7. Review and discuss all reports prior to their distribution; and
8. Distribute report to participating transit agencies and FTA giving feedback on close calls, emerging trends and newly identified risks, which were provided by the third party to the PRT.
 | PRT |
| 1. Review individual RTAs’ decisions on corrective actions.
 | RTA |
| 1. Provide the third party with information on decisions made with respect to corrective actions (see section 11).
 | RTA |
| 1. Track corrective actions taken in response to close call events. Share this information with the third party.
 | PRT |
| 1. Make feedback available to employees on corrective actions.
 | Third party / Contractor |
| 1. Draft quarterly report to summarize emerging trends and corrective actions; distribute to all participants and FTA and put on a Close Call Safety Reporting System website.
 | Third party / Contractor |
| 1. Write an annual report describing the status of the project, any modifications made and lessons learned to date; describe emerging trends and recommended solutions; distribute and put on a Close Call Safety Reporting System website.
 | Third party / Contractor |

Reporting, tracking, and corrective action monitoring systems all will be developed and improved over time.

# Eligibility

The Close Call Safety Reporting System pilot project applies to RTAs and their employees who are included in an implementing MOU, as provided in section 12. An individual transit agency employee filing a close call report in accordance with section 7 must belong to an included group and be performing in a role covered under an implementing MOU in order to receive protection from RTA discipline. Whenever feasible, all employees and contractors of an RTA should be included in the implementing MOU.

# Reporting Procedures

When an employee of an RTA included in an implementing MOU observes a safety problem or experiences a close call event, he or she should note the problem or event and describe it in enough detail using the third-party close call reporting form so that it can be evaluated by the third party and the PRT. (All reports will be depersonalized by the third party before the PRT sees them.)

## Criteria for close call report acceptance

Employees of RTAs participating in the close call safety reporting pilot project can report any safety concern that could lead to an unsafe event or condition on the RTA. Reports can be accepted for any condition or event that is perceived as potentially endangering employees, the public, equipment, or the environment. Any concern about one’s own safety or someone else’s safety at work can be reported. Each close call report must contain sufficiently detailed information about a safety event so that a third party can evaluate it. An interviewer may call the employee to obtain more information about the event; if in doubt, the interviewer will err on the side of accepting the report.

The third party will conduct the first screening and the PRT may conduct a second. The following types of reports will be rejected:

1. Reports unrelated to transit agency safety;
2. Urgent real-time issues (e.g., a runaway train);
3. Personal grievances; and
4. Labor organization management grievances.

## Close call report form

The third party will develop a close call report form (physical or electronic) that will request information about the date, time, location, contributing factors, actions taken, potential consequences, along with enough other information to fully describe the event or perceived safety problem. The employee should complete the report form and submit it by the mechanism identified in the implementing MOU to the third party in accordance with the instructions on the form. The third party will mail a receipt to the employee. All reports will be depersonalized by the third party before the PRT sees them.

The third party will provide paper copies of the blank report form to the RTAs and labor organizations participating in the close call safety reporting pilot project; participating RTAs will post submission instructions and forms on company bulletin boards and employee websites.

## Time limit to file report and receive protection from RTA discipline and FTA/SSO enforcement

An employee must report an event within a timeframe established in the implementing MOU after the occurrence of the event to receive protection from RTA discipline and FTA/SSO enforcement.

If access to the established reporting mechanism(s) is not available, the employee may file a close call report with the third party via telephone within the timeframe established in the implementing MOU. The third party will record the date and time that the close call report telephone call is made. Reports submitted by telephone outside the established timeframe will be rejected as non-qualifying reports.

Reports filed by telephone must be followed, within an established time frame, by a formal written close call report submission to the third party that is submitted via the established standard reporting mechanism(s). The third party will record the date and time that written reports are received and will determine if the report meets the timeframes established by the MOU. Qualifying reports must also meet all other acceptance criteria of the MOU and will be evaluated by the third party in the same manner as all other close call reports.

# Confidentiality

The third party shall act as the owner of the data reported to it by transit agency employees under the Close Call Pilot Project, and protect the confidentiality of this information through its own governance.

After the third party has determined that all relevant data from a close call event has been collected, the close call report should be de-identified so that the employee’s identity or anyone mentioned in the report can no longer be determined.

The third party shall protect the following information from disclosure when provided in a close call report:

1. The employee’s close call report and the content of that report;
2. The name of the employee who submits a close call report;
3. The name of any other employees mentioned in the close call report, regardless of whether or not they are part of the pilot;
4. The name of the RTA involved in the close call report;
5. Any other information that would make it obvious that only a few, easily identifiable people could have made the close call report; and
6. Evidence and other information gathered during a PRT evaluation of a close call report.

# Protection from RTA Discipline and FTA/SSO Enforcement

## Background

Since the main purpose of this Close Call Safety Reporting System is for the transit agency industry to learn more about the safety risks it faces, a central element is to shield employees from RTA discipline and FTA/SSO enforcement.

Shielding people and RTAs from blame creates an environment where employees and managers feel more comfortable disclosing information. Successful close call safety reporting systems protect the identity of the person disclosing information, and use the information for learning about system problems and coaching employees. Reporting unsafe conditions and actions are fostered in an environment where the organization wants to learn why the system failed and focus on improving it.

## Conditions that protect a reporting employee or RTA from discipline or enforcement action

Except as provided below and in Section 9.3, RTA employees included in an implementing MOU, who report close calls in accordance with section 7, receive protection from discipline by their employing RTA. RTA protection from FTA/SSO enforcement action requires that the same conditions apply:

1. The employee's action or lack of action was not intended to cause damage to the RTA’s operations, equipment, or personnel; and
2. The employee reports the unsafe condition within the time limits set forth in section 7.3, and the report is accepted as provided in section 7.1.

Employees that file an accepted close call report are protected from discipline by their employing RTA, and RTAs are protected from FTA/SSO enforcement action, arising from the **retrospective** discovery of events involving violations of operating practices involving the event reported. This includes the **retrospective** (as opposed to real time) use or review of event recorder data.[[7]](#footnote-7)

RTAs and the FTA/SSO are prohibited from using any information contained in an accepted close call report to pursue any disciplinary or enforcement action.

## Conditions when a reporting employee is not protected from RTA discipline and the RTA is not protected from FTA/SSO enforcement

Events that do not qualify for protection from RTA discipline or FTA/SSO enforcement action under the close call safety reporting system must be defined by the stakeholders of each individual implementing MOU. What follow are examples of events that the implementing MOU signatories are likely to consider excluding:

1. The employee's action or lack of action was **intended** to damage the RTA’s operations or equipment, or injure other employees, or the employee’s action or lack of action purposely places others in danger (i.e., sabotage);
2. The employee's action or lack of action involved a criminal offense;
3. The employee’s behavior involved substance abuse or inappropriate use of controlled substances;
4. The close call report contains falsified information;
5. The event resulted in a transit agency accident/incident that qualifies as reportable under State or Federal law;
6. The event resulted in an identifiable release of a hazardous material; or
7. The event was observed in real time and reported to the RTA (such as a dispatcher or operator observing a signal violation) or was observed as part of Operating Practices Testing.[[8]](#footnote-8)

Operating Practices Testing (e.g., efficiency testing, train control signal testing) are generally real-time observations and do not qualify for exemption. Similarly, an employee is not exempt from RTA discipline for a violation that the RTA or FTA identifies contemporaneously (e.g., a block goes red and the dispatcher notices it before the train backs off the circuit) before the employee files a close call report; in such situations, an RTA or FTA may use event recorder information to support discipline. For example, an RTA official who observes a train operate past a signal that requires a stop may use any relevant data recorded by the locomotive’s event recorder in pursuing disciplinary action against the train crew, regardless of whether a member of the crew timely files a close call report.

Other than what is stated above, there are no other changes to the RTAs’ disciplinary systems or FTA/SSO enforcement systems.

## Conditions when a participating RTA is and is not protected from FTA/SSO enforcement action

The FTA and SSO will also afford protection from regulatory enforcement action to an RTA covered by an implementing MOU for any incident for which an accepted close call report is filed regarding an employee of the RTA if that employee is protected from RTA discipline pursuant to the terms of this section.

# Use of Data

 All participants in the Close Call Safety Reporting Pilot Project agree to use the information they acquire for positive purposes to improve safety. This could include new or modified training, assessing risk and allocating resources to address those risks, and learning why these reported unsafe events are taking place. The RTAs agree to refrain from using this data for the purpose of discovering who else might be engaged in the same activity, and disciplining employees for that behavior.

# Corrective Actions

Corrective actions are the actions taken by RTAs in response to the PRT’s reports of emerging trends and new types of safety-critical events.[[9]](#footnote-9) Criteria for corrective action and corrective action reporting are: 1, it is not a burden to communicate; and 2, it is not intrusive to monitor.

# Stakeholders’ Responsibilities in Support of the MOU

The rights, roles, and responsibilities set forth in this MOU apply only to participants in the Close Call Safety Reporting Pilot Project pursuant to implementing MOUs that have been approved by FTA. If a pilot project involves a waiver of any FTA rules, the parties shall submit a waiver request.

There are five primary stakeholder organizations that will be involved in the pilot project. These include:

1. FTA Office of Safety, which will fund and sponsor the program for the industry and will consult on the project’s goals and implementation plan;
2. The third party, which will collect and analyze the reporting data;
3. The program evaluation organization chosen by FTA, which will coordinate the pilot project, conduct the program evaluation, and provide staff support to the project;
4. The RTAs, which will implement the reporting system on their respective transit agency; and
5. The labor organizations, which will represent the employees providing the close call reports.

## FTA's responsibilities in support of the MOU

FTA will oversee the scope and quality of the work. Experience gained from other modes has indicated that the willingness of persons to submit a close call report depends to a large degree on preserving the RTA’s and the employee’s confidentiality as well as that of persons named in those reports. Accordingly, FTA agrees to “stay at arm’s length from the close call reports before the identifying information (see section 5.3) has been removed.” FTA will not seek, and the third party will not release to FTA, any information that might reveal the identity of such persons or organizations mentioned in close call reports.

Specific FTA responsibilities include the following activities:

1. Fund the Close Call Safety Reporting Pilot Project if Congress appropriates funds for the project. The duration of the project is dependent upon continued Congressional funding. As provided in section 14, any party may terminate their participation in the project at any time. The amount of advance notice that must be provided will be set forth in the implementing MOUs.
2. Approve the project plan, budget, and detailed implementation.
3. Identify and prepare pilot sites.
4. Assign FTA employees to work on the PRT to analyze and summarize emerging trends as well as to recommend corrective actions.
5. Monitor implementation of the MOU in cooperation with all other signatories.
6. Monitor the evaluation of the project.
7. Consult on the project’s organization, goals, objectives, elements, and high-level implementation plan.
8. Develop a model corrective action protocol, which is a communications system with a feedback loop between the RTA, the third party, and the PRT.
9. Propose industry-wide corrective actions to address new sources of risk and emerging trends.

## Third party’s responsibilities in support of the MOU

The third party’s responsibilities in support of the MOU are to manage the implementation of the close call safety reporting system and protect the confidentiality of the data. The third party will act as the owner of the data, and protect the confidentiality of this information through its own governance, administrative protocols, CIPSEA, or other methods as applicable.

Other tasks include the following:

***Project planning***

1. Design the project’s organization structure; goals, objectives, elements; project plan; draft of budget; high-level implementation plan; detailed implementation plan; and oversight and management of pilot program.
2. Provide training to applicable employees and managers, and integrate with other related efforts.
3. Provide a system for the transit agency employees to report close calls, confidentially, including processes and procedures for data collection, and analysis and interpretation of reports.
4. Provide a process for rigorous quality assurance of data input, output, content, and timeliness.
5. Manage a Close Call Safety Reporting System website.

***Manage reporting system***

1. Enter close call report in the tracking system if it meets acceptance criteria.
* Confirm eligibility (see section 7.1).
* Date stamp and assign number.
* Mail a receipt to the employee.
1. Call the employee(s) to collect additional details about close call event or unsafe condition. If it meets acceptance criteria, report receives final acceptance.
2. De-identify close call report.
3. Analyze individual close call report for preliminary root causes and error recovery mechanisms. Analyze multiple reports for emerging trends and new sources of risk. Produce a report based on the collected data and forward to the PRT for analysis.
4. Make feedback on corrective actions available to RTA employees and union members.
5. In cooperation with the PRT, draft quarterly report to summarize emerging trends and corrective actions. Distribute to all participants in the Close Call Safety Reporting Pilot Project, including FTA, and put on a Close Call Safety Reporting System website.
6. Write an annual report describing the status of the Close Call Safety Reporting Pilot Project, any modifications made and lessons learned to date; describe emerging trends and recommended solutions; distribute to all participants in the Close Call Safety Reporting Pilot Project, including FTA; and put on a Close Call Safety Reporting System website.
7. Monitor implementation of the MOU in cooperation with all other signatories.

***Analyze collective reports***

1. Analyze data from multiple reports.
2. Identify emerging trends and new types of safety-critical events within and across the pilot sites.
3. Review and discuss a summary report comprised of the individual close call reports, emerging trends, identified root causes and suggested corrective actions. Assess the association between emerging patterns or trends in close calls and relate those to corrective actions taken by the RTAs.
4. Give input into a trend analysis report that analyzes the individual reports, emerging trends, identified root causes and suggested corrective actions.
5. Review and discuss all reports prior to their distribution.

***Program evaluation***

The success of the Close Call Safety Reporting Pilot Project depends upon its implementation and how it impacts safety at each of the participating transit agencies. A program evaluation will be conducted in a way to facilitate the smooth implementation of the project and measure the project’s effectiveness in improving safety with a minimal burden to the participating transit agencies. The program evaluation organization chosen by FTA will conduct the program evaluation component of this project with support from a third party. The following tasks related to program evaluation will be performed:

1. Collect baseline measures of safety and reporting culture for each participating transit agency.
2. Measure performance by tracking safety measures against the baseline to see if risk has been reduced.
3. Provide feedback to participants to improve the implementation of the Close Call Safety Reporting Pilot Project.
4. Write baseline report, mid-term report, and final report.

## RTA’s responsibilities in support of the MOU

RTAs participating in the Close Call Safety Reporting Pilot Project have the following responsibilities:

1. Commit to the use of this reporting system at all levels of the organization.
2. Consult on the high-level implementation plan and allocate funding each year dedicated to implementing corrective actions.
3. Assist in explaining the close call reporting system to employees as the program is initiated and providing ongoing training and communication to employees.
4. Two RTA representatives should participate on the PRT to analyze and summarize emerging trends as well as to recommend corrective actions.
5. Senior management and supervisors cannot preempt their respective representative’s decision-making discretion for an event reported.
6. The RTA should “stay at arm’s length from close call report data before the identifying information has been removed (see section 5.3).” The RTA should not seek any information that might reveal the identity of employees or individuals mentioned in a close call report.
7. The RTA will use the information collected from the Close Call Safety Reporting Pilot Project for the purpose of improving safety. The RTA agrees not to use the information for the purpose of disciplining employees.
8. Take corrective action in a timely manner.
9. Report corrective actions taken to the third party or report why no action was taken.
10. As an important means to achieve success in this pilot program, RTAs are encouraged to develop a communication plan for sharing findings with their employees.
11. Report on the measured effectiveness of corrective actions to the third party.
12. Monitor implementation of the MOU in cooperation with all other signatories.

## Labor organization’s responsibilities in support of the MOU

Labor organizations participating in the Close Call Safety Reporting Pilot Project have the following responsibilities:

1. Commit to the use of the close call safety reporting system at all levels of the organization.
2. Consult on the high-level implementation plan.
3. Representatives from each participating labor organization should participate on the PRT to analyze and summarize emerging trends as well as to recommend corrective actions.
4. Monitor implementation of the MOU in cooperation with all other signatories.
5. Assist in explaining the close call reporting system to employees as the program is initiated and providing on-going training and communication to union members.

## SSO responsibilities in support of the MOU

The SSO will provide expertise to the PRTs when feasible. The SSO will use the information collected from the Close Call Safety Reporting Pilot Project for the purpose of improving safety. The SSO will not use the information for the purpose of pursuing enforcement action against the participating RTA.

Specific SSO responsibilities include the following activities:

1. When feasible, assign SSO employees to work on the PRT to analyze and summarize emerging trends as well as to recommend corrective actions.
2. Monitor implementation of the MOU in cooperation with all other signatories.
3. Assist FTA in developing a model corrective action protocol, which is a communications system with a feedback loop between the RTA, the third party, and the PRT.

## Peer Review Team’s responsibilities in support of the MOU

The PRT consists of individuals from the primary stakeholders (RTAs, labor organizations, and SSO) to represent their employer’s perspectives in forming a comprehensive view of close call events. The PRT will be composed of two representatives from each of the following stakeholder groups: RTA management, the affected labor organizations, and the SSO.[[10]](#footnote-10) One representative from the third party will participate. The PRT will draw members from the local level of the primary stakeholders. Continuity of the PRT membership is essential for success.

The PRT will meet at a minimum on a quarterly basis. Their primary responsibilities include the following:

***Analyze each individual close call report after the identifying information has been removed***

1. Analyze each close call report after the identifying information has been removed (see section 5.3), and validate the root causes of the reported incidents.
2. Propose corrective actions.
3. Track the RTA’s follow through on the implementation of corrective actions.
4. Track the effectiveness of an RTA’s implemented corrective actions and their impact on a pilot site’s safety.

The PRT will function using, but not be limited to, the following guidelines:

1. The team can conduct business only when a quorum is present. A quorum exists when all designated representatives, or their alternates, are present. The designated representative will name an alternate to act when the designated representative is unable to attend.
2. The primary stakeholders on the PRT are encouraged to consult with their constituents and additional FTA or industry experts for guidance on complex or sensitive matters, where more information is desired to make an informed decision.
3. The PRT will conduct its own root-cause analysis, driven by the risk data (and a preliminary root-cause analysis) provided by the third-party agency.
4. Each representative is empowered to offer possible sources of risk, error recovery mechanisms, and corrective actions. Diverse perspectives are expected and encouraged. The PRT’s opinions reflect a collaborative decision-making process among all PRT representatives.
5. The PRT makes its decisions using “consensus” when assigning root causes and proposing corrective actions. Consensus means the voluntary agreement of all representatives. It does not require that all members believe that a particular decision is the best one. Instead, all representatives’ positions are given a proper hearing and are addressed, and a decision is one that all can accept.
6. The team will protect the confidentiality of the reporting employee, any employee mentioned in the close call report and the RTA for any report they review. The team will not disclose any information that would make it possible to identify the reporting employee(s) mentioned in the close call report, or the RTA.
7. The PRT will meet in a mutually convenient central location.

# Modifications

Modifications to this MOU may be proposed at any time during the period of performance by any party to the MOU, and shall become effective upon written approval by all parties.

# Project Duration

This MOU is in effect for three (3) years from the date of execution, and may be renewed by written agreement of the participants. Participants in the project may terminate their participation in the project; the amount of advance written notice they must provide will be set forth in the implementing MOUs.

Termination or modification of this agreement or an implementing MOU should not adversely affect anyone who acted in reliance on the terms of an implementing MOU in effect at the time of that action; i.e., when a particular project is terminated, all reports and investigations that were in progress should be handled under the provisions of the program until they are completed. If significant disputes arise between any of the signatory parties regarding the implementation of the terms of the MOU these will be settled through a resolution process with FTA. In addition, as described in Section 12.3, failure of an RTA to reasonably follow through with corrective action acceptable to the PRT to resolve any safety deficiencies that have been identified under the project within a reasonable time frame could result in termination of the RTA’s implementing MOU and, if necessary, the subsequent development of safety and enforcement tools by FTA in its transit agency safety oversight role, as noted in Section 3.

This is a pilot program. If the program is determined to be successful after a comprehensive review and evaluation, the parties intend that it will be the basis for a continuing program, although not necessarily funded by FTA.

# Record Keeping

All records and documents relating to this program should be appropriately kept in a manner that ensures compliance with applicable third-party and CIPSEA regulations, if applicable.

# Funding

Continuation of work under the Close Call Safety Reporting Pilot Project is contingent on the future availability of FTA funds.

# Responsible Officials

The officials responsible for signing this MOU are the FTA Administrator, the Third Party Director, and the RTA Chief Executive Officer.

When top leadership changes in any of the participating organizations, it is expected that outgoing managers should ensure that their successors understand the value of this program. Incoming leaders would need to co-sign this document to agree to its intent.

# Cooperating Organization Signatures

# *[This section is where the cooperating organizations indicate their support for the implementing MOU, and sign the document as a showing of good faith.]*

# Appendix C: Detailed Recommendations for Pilot Program Evaluation

The suggested close call safety reporting pilot program should be evaluated for two primary reasons:

1. To ensure that the pilot program is successful in producing value to the safety of rail transit systems; and
2. To identify areas of needed improvement and resources for implementation beyond the pilot sites.

The evaluation primarily should determine if the pilot was successful in its goal to produce hazard identifications that otherwise would not have been identified and mitigated. In this regard, the working group makes the following detailed recommendations:

**Develop a Logic Model**

Consistent with traditional program evaluations, a logic model illustrates the program theory or how the program is intended to work. It provides a visualization of how different components and resources are intended to function, and thus serves as a helpful diagnostic and demonstration tool.[[11]](#footnote-11)

**Document Program Inputs**

It will be important to know what resources were available and successfully used. The information would be useful for rolling the program out beyond the pilot projects, and in identifying areas where extra resources might be advised.

1. Management, labor, regulators: dedicated time and participation.
2. Funding.
3. Workplan.
4. Confidentiality and data collection mechanism/entity.
5. Report review team.
6. Program evaluation tasks and resources.
7. Initial conditions at the beginning of each pilot project, including labor relations, safety performance, employee involvement and engagement in safety, and others.

**Document Program Outputs: Implementation activities, tasks, benchmarks, and indicators** Documentation of the implementation ensuring all components were established and working as designed.

1. Comprehensive jointly crafted MOU satisfactory to management, labor, and regulators.
2. Workable means and structures for reporting, including confidentiality protections.
3. Awareness of program and purpose.
4. Participation of members in reporting hazards.
5. Procedures: Easy to use and well-known?
6. Establishment of a report review team.
7. Mechanisms for taking action where needed.
8. Feedback to reporters.
9. Trust between reporting individuals and management, regulators, and the system.
10. Program evaluation report.
11. Were resources sufficient to produce the desired inputs?
12. To what extent was the close call reporting system utilized at each of the pilot sites?
13. Were there any common events reported between the pilot sites and were the pilot RTAs able to share strategies they each used among themselves?
14. Were there RTA’s that were not part of the pilot, but able to address similar events they experienced by reviewing and implementing strategies used by the pilot RTAs?

**Document Program Outputs: Descriptive statistics**

Data documenting and describing pilot project activities would cover the implementation in terms of time spent, close call reports filed, follow-up reports issued, etc.**:**

1. Time required to complete MOU from beginning to end
	1. Elapsed time.
	2. Calendar days.
	3. Percent of total pilot duration.
2. Report volume
	1. Number of total reports.
	2. Percent of total reports accepted as valid.
3. Follow-through / analysis of close calls
	1. Rate of follow-up with reporting employees.
	2. Number of valid reports resulting in action.
4. Educational Materials / Bulletins
	1. Number of documents developed.
	2. Number of documents distributed/used within agency.
	3. Number of documents distributed/used within broader transit industry.
5. Procedural Changes
	1. Number of process/procedures changed within agency.
	2. Number of process/procedures changed within broader transit industry.

**Identify Primary Substantive Outcomes: Safety information and mitigation**

These would be the most important pilot evaluation criteria and the primary category to inform a decision as to whether or not to establish a nationwide system based on the pilots. Did the pilot result in new, useful information that would otherwise not have been available that was acted upon to benefit safety? These might be called safety-performance affecting variables, and should be sufficiently validated by the experiences of other transportation modes to provide confidence as surrogates for the more elusive actual safety performance measures.

1. Safety improvement. Reduction of hazards, risks.
2. Identification of hazards. Hazards that otherwise would not have been brought to the attention of those they affect and those who can take action to mitigate the hazards.
3. Extent of change in the completeness of close call and safety issue reports.
4. Extent of change in the number of close call reports.
5. Extent of change in the number of follow-up reports to close call reports.
6. Extent of change in the reporting of other safety issues.
7. Ability to determine hazard pervasiveness. Unique occurrence, pervasive, or increasing, trending?
8. Collection of hazard information useful for remedial action for single hazard instances and for emerging hazard trends.
9. Expansion of safety information pool – those who engage in safety improvement and development.
10. Are actions taken to reduce identified hazards?
11. Participation of all members of the organization in hazard identification and reduction, especially those closest to the hazards.
12. Empowerment of members who otherwise might think it either futile or personally harmful to engage in hazard identification and reduction.
13. Safety performance in terms of injuries and accidents and any trends. Because safety improvement is the ultimate goal, it would be good to at least attempt direct measures of safety performance, such as injury and accident rates and trends. However, this could be the most difficult part of the evaluation for many reasons. Evaluation would be especially problematic if the pilot sites were a select set of already high-performing agencies, because safety performance measures for such sites initially may only provide little variability in safety performance. Safety performance measures may not be sensitive enough to be used for decision-making purposes since they are subject to many external influential variables that likely could overshadow the little variability in high-performing pilot sites. In summary, if measures 1 through 12 show significant changes, but safety performance does not, decisions for rollout should depend on these 12 measures because it may not be possible to confidently conclude what caused any trend, or lack of trend, in the safety performance measures.

**Identify Other Substantive Outcomes: Organizational benefits, program diagnostics**

The evaluation should examine how participants view the pilot project.The extent and value of measurement and evaluation using the following criteria will likely depend on availability of resources to produce quality surveys. A survey whose results could generate any confidence in its conclusions could be expensive, although even simple surveys could identify issues needing attention. While we believe that these criteria should not be a determinant for proceeding with new rollouts, they would be important and could be useful input for new rollouts.

1. **Self-reported attitudes.** Many additional benefits are possible through the experience of a successful confidential close call safety reporting system. These benefits ultimately can contribute to the organization’s safety culture, overall health, and ultimate survival. Many of those benefits can be characterized as quality of work life. Evaluation might include measures of attitudes and perceptions, such as trust, justice, empowerment, self-efficacy in safety, job satisfaction, organizational citizenship behavior, and others. Impacts such as these are most commonly tracked as changes in attitudes about work and are measured through surveys.

However, recognizing that the ability of surveys to provide data-quality sufficient to make confident conclusions presents several difficulties. Other events and experiences can often overshadow the effect of the topic of interest. The lack of a sufficient return rate can prevent representative conclusions from being made. Outcomes that lag much behind the primary outcomes are difficult to assess. Yet it would be ideal to attempt information-gathering of these secondary outcomes if for no other reason but to find out what work needs to be done. For example, even with a low return rate, if many opinions suggested less than satisfactory acceptance, that would be an important finding in that we would know that at least a segment of the organization needed more buy-in opportunities than they perceived. Even low return rates can provide useful information about particular concerns with specific components of a program, at least for a subset of the participants.

Possible questions might include:

* Are all aspects of the program perceived as fair?
* Do employees experience a more “just” organization?
* Do individuals perceive greater self-efficacy in safety improvement?
* Do employees feel safer as a result of the program?
* Is safety perceived as a higher organizational priority as a result of the program?
* Do employees trust the program?
* Has the program made a difference in the way employees perceive close calls?
* Has the program made a difference in the way employees act on close calls?
* Are employees more likely to evaluate/analyze near-miss situations?
* Do employees perceive the program to be valuable?
* What components of the program need changing and why?
* Are employees finding their job more satisfying after the pilot?
1. **Possible existing attitude scales:**
	* Safety Culture and Climate attitudes or sub-scales, and changes due to the program; i.e., measures before and after the program.
	* Job satisfaction scales or sub-scales, and changes due to the program.
	* Organization Citizenship Behavior scales or sub-scales, and changes due to the program.
2. **Possible behavioral measures:**
	* Change in frequency of grievances.
	* Absenteeism changes.
	* Change in frequency of reported soft tissue injuries where there is no hard evidence of injury.

# Appendix D: Certificates of Confidentiality

Another possible alternative to ensure confidentiality of the close call safety reporting system is the Certificate of Confidentiality (COC) provided by the National Institutes of Health (NIH). Traditionally used for research projects, COCs protect identifiable research information from forced disclosure in any civil, criminal, administrative, legislative, or other proceeding, whether at the Federal, State, or local level. It may be possible to apply for a COC from NIH for a confidential, non-punitive, close call reporting program on the basis that injuries and fatalities are a national health hazard. However, the TRACS Working Group recommends that FTA conduct a legal analysis regarding the applicability and suitability of COCs to protect close call reporting program data.

**What follows is a reprinting of guidance published by NIH on the purpose of COCs, the statutory authority that enables NIH to issue them, and the extent and limitations under which they can be used.** [[12]](#footnote-12)

## Purpose

Certificates of Confidentiality are issued by NIH to protect the privacy of research subjects by protecting investigators and institutions from being compelled to release information that could be used to identify subjects with a research project. Certificates of Confidentiality are issued to institutions or universities where the research is conducted. They allow the investigator and others who have access to research records to refuse to disclose identifying information in any civil, criminal, administrative, legislative, or other proceeding, whether at the Federal, State, or local level.

Identifying information is broadly defined as any item or combination of items in the research data that could lead directly or indirectly to the identification of a research subject.

By protecting researchers and institutions from being compelled to disclose information that would identify research participants, Certificates of Confidentiality help achieve the research objectives and promote participation in studies by assuring privacy to subjects.

## Statutory Authority

Under section 301(d) of the Public Health Service Act (42 U.S.C. 241(d)) the Secretary of Health and Human Services may authorize persons engaged in biomedical, behavioral, clinical, or other research to protect the privacy of individuals who are the subjects of that research. This authority has been delegated to the National Institutes of Health (NIH).

Persons authorized by the NIH to protect the privacy of research subjects may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings to identify them by name or other identifying characteristic.

## Extent and Limitations of Coverage

Certificates can be used for biomedical, behavioral, clinical, or other types of research that is sensitive. By sensitive, we mean that disclosure of identifying information could have adverse consequences for subjects or damage their financial standing, employability, insurability, or reputation.

 Examples of sensitive research activities include but are not limited to the following:

* Collecting genetic information;
* Collecting information on psychological well-being of subjects;
* Collecting information on subjects' sexual attitudes, preferences or practices;
* Collecting data on substance abuse or other illegal risk behaviors;
* Studies where subjects may be involved in litigation related to exposures under study (e.g., breast implants, environmental or occupational exposures).

In general, certificates are issued for single, well-defined research projects rather than groups or classes of projects. In some instances, they can be issued for cooperative multi-site projects. A coordinating center or "lead" institution designated by the NIH program officer can apply on behalf of all institutions associated with the multi-site project. The lead institution must ensure that all participating institutions conform to the application assurances and inform participants appropriately about the Certificate, its protections, and the circumstances in which voluntary disclosures would be made.

A Certificate of Confidentiality protects personally identifiable information about subjects in the research project while the Certificate is in effect. Generally, Certificates are effective on the date of issuance or upon commencement of the research project if that occurs after the date of issuance. The expiration date should correspond to the completion of the study. The Certificate will state the date upon which it becomes effective and the date upon which it expires. A Certificate of Confidentiality protects all information identifiable to any individual who participates as a research subject (i.e., about whom the investigator maintains identifying information) during any time the Certificate is in effect. An extension of coverage must be requested if the research extends beyond the expiration date of the original Certificate. However, the protection afforded by the Certificate is permanent. All personally identifiable information maintained about participants in the project while the Certificate is in effect is protected in perpetuity.

Some projects are ineligible for a Certificate of Confidentiality. Not eligible for a Certificate are projects that are:

* not research,
* not collecting personally identifiable information,
* not reviewed and approved by the Institutional Review Board as required by these guidelines, or
* collecting information that if disclosed would not significantly harm or damage the participant.

While Certificates protect against involuntary disclosure, investigators should note that research subjects might voluntarily disclose their research data or information. Subjects may disclose information to physicians or other third parties. They may also authorize in writing the investigator to release the information to insurers, employers, or other third parties. In such cases, researchers may not use the Certificate to refuse disclosure. Moreover, researchers are not prevented from the voluntary disclosure of matters such as child abuse, reportable communicable diseases, or subject's threatened violence to self or others. (For information on communicable disease reporting policy, see [Communicable Diseases Policy](http://grants.nih.gov/grants/policy/coc/cd_policy.htm). However, if the researcher intends to make any voluntary disclosures, the consent form must specify such disclosure.

Certificates do not authorize researchers to refuse to disclose information about subjects if authorized Department of Health and Human Services (DHHS) personnel request such information for an audit or program evaluation. Neither can researchers refuse to disclose such information if it is required to be disclosed by the Federal Food, Drug, and Cosmetic Act.

In the informed consent form, investigators should tell research subjects that a Certificate is in effect. Subjects should be given a fair and clear explanation of the protection that it affords, including the limitations and exceptions noted above. Every research project that includes human research subjects should explain how identifiable information will be used or disclosed, regardless of whether or not a Certificate is in effect. The Office of Human Subjects Protection (OHRP) provides guidance on the content of informed consent documents. For additional information, see <http://www.hhs.gov/ohrp/archive/irb/irb_chapter3.htm>

## An Important Caveat

*Certificates of Confidentiality do not take the place of good data security or clear policies and procedures for data protection, which are essential to the protection of research participants' privacy. Researchers should take appropriate steps to safeguard research data and findings. Unauthorized individuals must not access the research data or learn the identity of research participants.*

## Instructions for Applicants

Any person engaged in research collecting sensitive information from human research subjects may apply for a Certificate of Confidentiality. NIH is authorized to issue this privacy protection, in its discretion, for important research within its mission areas. The purpose of this statutory authorization is, in part, to reduce impediments to biomedical/bio-behavioral research subject recruitment. NIH provides detailed instructions for investigators wishing to make an application. Detailed application instructions for extramural scientists can be found at <http://grants.nih.gov/grants/policy/coc/appl_extramural.htm>. Detailed application instructions for intramural scientists can be found at <http://grants.nih.gov/grants/policy/coc/appl_intramural.htm>. Additional information is available on the [Frequently Asked Questions](http://grants.nih.gov/grants/policy/coc/faqs.htm) page.

The application, which should be submitted on the research institution's letterhead, requires information about the PI, the grantee institution, and the project. However, on a case-by-case basis, some NIH Institutes and Centers (ICs) may require additional information in order to assist them in carrying out their discretionary authority to issue Certificates of Confidentiality. Therefore, it is important that applicants consult their funding IC prior to submitting an application for a Certificate of Confidentiality. Investigators conducting sensitive research that is not supported with NIH funds may apply for a certificate through the NIH. They should contact the NIH IC that supports work in the same substantive area. Alternatively, they can contact one of the ICs serving as a Central Certificate Resource. For a list of Certificate contacts, see <http://grants.nih.gov/grants/policy/coc/contacts.htm>.

In addition to the completed form, the Principal Investigator (PI) will be required to provide documentation of Institutional Review Board (IRB) approval and a copy of the informed consent forms as it would read if a Certificate of Confidentiality is obtained – explaining the Certificate, its protections and the circumstances in which voluntary disclosures might be made, i.e. to protect the subject or others from serious harm. The completed package should be sent to the Certificate Coordinator at the appropriate NIH IC.

In cases where a Certificate of Confidentiality is sought for a student research project, the letter of application must be submitted on institutional stationery and signed by three people: the student, the student's advisor or other appropriate faculty member, and the Institutional Official. Also, NIH prefers that the faculty sponsor be designated as the PI on such applications instead of the student; a post-doctoral student can be listed as the co-PI. Moreover, the IRB approval for a student research project must be issued jointly to the student and the advisor or to the advisor with a copy to the student.

The Certificate is issued by the NIH based on the application from the PI for a specific research project. The Certificate is granted to the investigator's institution. If more than one institution is participating in a multi-site project, the PI at the coordinating center or "lead" institution applies for the Certificate on behalf of all sites, listing each participating unit, its address and project director in the application. A single Certificate for such multi-site projects is issued, and the lead institution is responsible for distributing copies of the Certificate to each participating unit or site.

If the PI relocates to a new institution during the course of the project, he or she should apply for an amendment to the existing Certificate. If there are significant modifications to the project or the informed consent form, the PI should contact the Certificate Coordinator that issued the Certificate. Significant changes to the project may require a modification to the existing Certificate or an application for a new Certificate if there is substantial change in the scope of research. If the project is not completed in the time specified in the application for the Certificate, the PI should apply for an extension to the expected date of completion of the project. Requests for modifications, amendments, and extensions should be submitted three months prior to the date needed and should be accompanied by a reason for requesting it and documentation of the most recent IRB approval.

Both the PI and the Institutional Official are required to sign the Certificate application. In doing so, they are agreeing to the assurances as stated in the application form. (See <http://grants.nih.gov/grants/policy/coc/appl_extramural.htm>.) The name, title, and address of the Institutional Official should be typed below the signature.

NIH Intramural Investigators may also apply for Certificates of Confidentiality. Detailed instructions for Intramural investigators are available at <http://grants.nih.gov/grants/policy/coc/appl_intramural.htm>. When possible, an application for a Certificate should be made in conjunction with initial or annual IRB review of research proposals. Intramural PIs should complete the application form and attach a concise description of project aims and research methods (this can be met by attaching a copy of the protocol), IRB approval (memo signed by the IRB Chair), and a copy of the informed consent form to be used in the study, as approved by the IRB. Completed packages should be sent to the Certificate Coordinator at the appropriate NIH IC.

## Flow Chart

The following chart (Fig. 1) is a summary of the process to determine eligibility for a Certificate and appropriate contacts. The following NIH Institutes/Centers (ICs) are using an on-line application process: [NCCAM](http://grants.nih.gov/grants/policy/coc/contacts.htm%22%20%5Cl%20%22nccam), [NCRR](http://grants.nih.gov/grants/policy/coc/contacts.htm#ncrr), [NHLBI](http://grants.nih.gov/grants/policy/coc/contacts.htm#nhlbi), [NIAAA](http://grants.nih.gov/grants/policy/coc/contacts.htm#niaaa), [NIAID](http://grants.nih.gov/grants/policy/coc/contacts.htm#niaid), [NICHD](http://grants.nih.gov/grants/policy/coc/contacts.htm#nichd), [NIEHS](http://grants.nih.gov/grants/policy/coc/contacts.htm#niehs), [NIMH](http://grants.nih.gov/grants/policy/coc/contacts.htm#nimh), [NINDS](http://grants.nih.gov/grants/policy/coc/contacts.htm#ninds), [NINR](http://grants.nih.gov/grants/policy/coc/contacts.htm#ninr). To access the on-line system for one of the IC’s, please click on one of the IC's listed or go to the IC listing on the Contacts List: <http://grants.nih.gov/grants/policy/coc/contacts.htm>



**Fig. 1 Flow Chart to Determine Eligibility for a CoC and Appropriate Contacts**

1. Certificates of Confidentiality (COCs) are at times used to protect the confidentiality of research project data. The TRACS Working Group is unsure of the applicability or suitability of COCs to close call reporting projects. Therefore, we recommend that FTA undertake a legal review to determine the applicability and suitability of COCs as a possible alternative option for protecting close call reporting data. See Appendix D for general information on COCs. [↑](#footnote-ref-1)
2. The working group recognizes that there are professional guidelines for program evaluations and does not want to be seen as dictating an evaluation, but wants to ensure that the desired primary outcomes are the focus of the evaluation. For example, see Mattessich, Paul W. (2003) *The Manager’s Guide to Program Evaluation: Planning, Contracting, Managing for Useful Results*. St. Paul, MN: Fieldstone Alliance Publishing Center and <http://www.wmich.edu/evalctr/archive_checklists/kec_feb07.pdf>. [↑](#footnote-ref-2)
3. Recommendations are consistent with **TCRP Report #149, Table 11: *Best Practices Checklist for Implementing a Safety Reporting System.***  [↑](#footnote-ref-3)
4. For example, the report states that in 1995, “the Safety Board provided a survey form to the Brotherhood of Locomotive Engineers (BLE) and the UTU requesting a description of any unusual signal occurrences. A total of 95 complaints were received from both organizations dating from February 1993.” (page 103). National Transportation Safety Board, Washington, DC 20594, Railroad Accident Report Collision and Derailment of Maryland Rail Commuter MARC Train 286 and National Railroad Passenger Corporation; AMTRAK Train 29; Near Silver Spring, Maryland on February 16, 1996; PB97-916302 NTSB/RAR-97/02. [↑](#footnote-ref-4)
5. Safety is defined as free from risk -- anything that helps avoid injuries, fatalities or equipment damage. [↑](#footnote-ref-5)
6. If initial report contains insufficient information to determine acceptance, report will receive provisional acceptance. Final eligibility will be determined when the interviewer obtains more information from the employee. [↑](#footnote-ref-6)
7. Using specific events or trends highlighted by the Close Call reporting system to identify, target, or discipline employees is outside the spirit of this project. “Event recorder” means a device, designed to resist tampering, that monitors and records data on train speed, direction of motion, time, distance, throttle position, brake applications and operations (including train brake, independent brake, and, if so equipped, dynamic brake applications and operations), and, where the train is so equipped, cab signal aspect(s), over the most recent 48 hours of operation of the electrical system of the train on which it is installed. [↑](#footnote-ref-7)
8. It might also include other real-time monitoring activities. [↑](#footnote-ref-8)
9. For the reporting system to be successful corrective actions must be implemented or no improvement will occur. Since the close call reporting system is not directly concerned with the internal operations of any RTA, it will not be possible to demonstrate a direct causal link between specific close calls reported and corrective actions taken by the RTAs. However, it may be possible to show an association between emerging patterns or trends in close calls and relate those to corrective actions taken by the RTAs. It also may be able to evaluate whether RTAs are following through on the number of corrective actions they agree to address. [↑](#footnote-ref-9)
10. This information is given for guidance only. Additional representatives may be added on a case-by-case basis to provide needed expertise. [↑](#footnote-ref-10)
11. Guidance for creating logic models is available at <http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html> [↑](#footnote-ref-11)
12. Source: National Institutes of Health, Office of Extramural Research; Certificates of Confidentiality Kiosk. <http://grants.nih.gov/grants/policy/coc/index.htm> [↑](#footnote-ref-12)