

DEPARTMENT OF TRANSPORTATION  
FEDERAL RAILROAD ADMINISTRATION

**FALSE PROCEED SIGNAL REPORT**

REPORT FOR (month/year)  
02/03

DATE March 4, 2003

REPORTING CARRIER (railroad & region or division)

CANADIAN NATIONAL  
ILLINOIS CENTRAL  
RAILROAD  
MIDWEST DIVISION

REPORTING OFFICER (signature & title)

Senior Officer Standards & Safety Assurance

All railroads subject to Regulations of the Federal Railroad Administration shall submit a false proceed signal report, original only, to the Federal Railroad Administration within five days after a false proceed occurs. If no false proceed occurs during any calendar month, a report showing "No Failures" must be filed within ten days after the end of the month.

Copies of this form will be furnished upon request to the Department of Transportation, Federal Railroad Administration, Office of Safety, Washington, D.C. 20590

**MAIL TO:**

Director of Railroad Safety  
Attention:  
Federal Railroad Administration  
111 North Canal Street Suite 655  
Chicago, Illinois 60606

A failure should not be counted more than one time in items 1, 2, 3, and 4: the failure should be classified under the basic system or appliance of which it forms an essential part. E.g.; assume grounds cause a block signal in indicate a false proceed causing corresponding indication of a cab signal system on each train approaching this point, such failures should be included in item 1, Block Systems. A false proceed failure is a failure of a system, device or appliance to indicate or function as intended which results in less restriction than intended.

The following abbreviations may be used in the report.

A=Automatic	EM=Electromechanical
AB=Automatic block	EP=Electropneumatic
ACS=Automatic cab signal	FP=False proceed
APB=Automatic permissive block	MB=Manual block
ATC=Automatic train stop	M=Mechanical
CL=Color light	P=Pneumatic
CPL=Color position light	PL=Position light
E=Electric	TC=Traffic control

TYPE OF SYSTEM	DATE	LOCOMOTIVE NUMBER	DEVICE THAT FAILED	LOCATION (city & state)
1 BLOCK SYSTEM <input type="checkbox"/> AB <input type="checkbox"/> APB <input type="checkbox"/> TC				
2 INTERLOCKING <input type="checkbox"/> AUTO-MATIC <input type="checkbox"/> REMOTE <input checked="" type="checkbox"/> MANUAL	2/21/2003	STCBCHI1	33 Crossover	Brighton Park, IL
3 AUTOMATIC SYSTEMS <input type="checkbox"/> ATS <input type="checkbox"/> ATC <input type="checkbox"/> ACS				
4 OTHER (specify)				

**NATURE AND CAUSE OF FAILURE, CORRECTIVE ACTION TAKEN.**

On February 21 at approximately 1730 hours Eastward train STCHCHI1 derailed 2 cars at #33 switch at 33 crossover at Corwith Interlocker. The route given displaying a permissive signal at 35 signal was 33 reverse, 39 normal, and 43 reverse to Santa Fe yard. A second incident had also occurred with the BNSF local reporting that after proceeding past a permissive signal switch 75 was lined reverse, against the established route. At the time of the derailment being reported, the Operator, was verifying in the field that 75 switch was lined reverse.

Signal Supervisor ; contacted Manager of the situation and the Interlocker was taken out of service. At approximately 1930 hour and Field Engineer arrived to investigate the incident. It was confirmed in the tower that levers 33, 35, 43 and 41 were pulled, which is correct for signal 35 to display a signal to proceed. Upon inspection of the derailment, it was determined that the #33 switch of the 33 crossover had moved from the reverse position to a position one inch from normal, while the other end of the crossover was still lined reverse. It was also discovered that and the Corwith Maintainer were replacing a polar relay for switch 34 while trains STCBCHI1 and the BNSF local were moving across the Interlocker. The relay change out started at approximately 16:30 hours and was completed at approximately 1700 hours. While the relay was pulled the Santa Fe main breaker (140VDC), which supplies control battery to the switch machines, was tripped open. At approximately 17:30 hours the main breaker had been reset. At this moment the Supervisor stated he had heard a couple of clicks for the control machine in the tower and within five minutes STCBCHI1 reports they had derailed at #33 switch at the crossover.

Further investigation of the interlocker included insulation resistance testing on all cables, ground tests, and verification of all routes. No exceptions were found during these tests. The incident could not be reproduced. Cause was determined to be human interference during the relay change out.