per response for the annual collection and processing of the HPMS data is 1,800 hours for each State, the District of Columbia and the Commonwealth of Puerto Rico.

Estimated Total Annual Burden: The estimated total annual burden for all respondents is 93,600 hours.

FOR FURTHER INFORMATION CONTACT: Mr. Robert Rozycki, (202) 366–5059, Department of Transportation, Federal Highway Administration, Highway Systems Performance (HPPI–20), Office of Highway Policy Information, Office of Policy & Governmental Affairs, 1200 New Jersey Avenue, SE., Washington, DC 20590. Office hours are from 7:30 a.m. to 4 p.m., Monday through Friday, except Federal holidays.

Public Comments Invited

You are asked to comment on any aspect of these information collections, including: (1) Whether the proposed collections are necessary for the FHWA's performance; (2) the accuracy of the estimated burdens; (3) ways for the FHWA to enhance the quality, usefulness, and clarity of the collected information; and (4) ways that the burdens could be minimized, including use of electronic technology, without reducing the quality of the collected information. The agency will summarize and/or include your comments in the request for OMB's clearance of these information collections.

Authority: The Paperwork Reduction Act of 1995; 44 U.S.C. ch. 35, as amended; and 49 CFR 1.48.

Issued On: September 30, 2011.

Michael Howell,

Acting Chief, Management Programs and Analysis Division.

[FR Doc. 2011–26199 Filed 10–7–11; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

[Docket No. FHWA–2011–0113]

Agency Information Collection Activities: Notice of Request for Renewal of a Previously Approved Information Collection

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of Request for Renewal of a Previously Approved Information Collection.

SUMMARY: The FHWA invites public comments about our intention to request the Office of Management and Budget's (OMB) approval of a new information collection that is summarized below under **SUPPLEMENTARY INFORMATION**. We are required to publish this notice in the **Federal Register** by the Paperwork Reduction Act of 1995.

DATES: Please submit comments by December 12, 2011.

ADDRESSES: You may submit comments identified by DOT Docket ID Number 2011–0113 by any of the following methods:

Web Site: For access to the docket to read background documents or comments received, go to the *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the online instructions for submitting comments.

Fax: 1–202–493–2251.

Mail: Docket Management Facility, U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.

Hand Delivery or Courier: U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m. E.T., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mary Huie, 202–366–3039, Department of Transportation, Federal Highway Administration, Office of Infrastructure, 1200 New Jersey Ave., SE., E76–106, Washington, DC 20590. Office hours are from 8 a.m. to 4:30 p.m., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Title: Highways for LIFE Pilot Program.

Background: Section 1502 of SAFETEA–LU establishes the ''Highways for LIFE'' Pilot Program. The purpose of the Highways for LIFE pilot program is to advance longer-lasting highways using innovative technologies and practices to accomplish the fast construction of efficient and safe highways and bridges. ''Highways for LIFE'' is focused on accelerating the rate of adoption of proven technologies. The program will provide funding to States to accelerate technology adoption to construct, reconstruct, or rehabilitate Federal-aid highway projects that incorporate innovative technologies that will improve safety, reduce congestion due to construction, and improve quality. Those States interested in participating in the ''Highways for LIFE'' program will submit an application for project funding. The information to be provided on the application includes a description of the project, the innovative technologies to be used and a description of how these technologies will improve safety, reduce construction congestion, and improve quality. The collected information will be used by FHWA to evaluate and select projects for ''Highways for LIFE'' funding.

Respondents: The fifty State Departments of Transportation, the District of Columbia, and Puerto Rico.

Frequency: Annually.

Estimated Number of Respondents: 1,460 for file maintenance and 52 state highway agencies for statistical reports.

Estimated Average Burden per Response: 8 hours per respondent per application.

Total Annual Burden: It is expected that the respondents will complete approximately 30 applications for an estimated 240 total annual burden hours.

Public Comments Invited: You are asked to comment on any aspect of this information collection, including: (1) Whether the proposed collection of information is necessary for the U.S. DOT's performance, including whether the information will have practical utility; (2) the accuracy of the U.S. DOT's estimate of the burden of the proposed information collection; (3) ways to enhance the quality, usefulness, and clarity of the collected information; and (4) ways that the burden could be minimized, including the use of electronic technology, without reducing the quality of the collected information. The agency will summarize and/or include your comments in the request for OMB's clearance of this information collection.

Authority: The Paperwork Reduction Act of 1995; 44 U.S.C. Chapter 35, as amended; and 49 CFR 1.48.

Issued on: September 30, 2011.

Michael Howell,

Acting Chief, Management Programs and Analysis Division.

[FR Doc. 2011–26201 Filed 10–7–11; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

[Safety Advisory 2011–02]

Following Procedures When Going Between Rolling Equipment

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Notice of Safety Advisory.

SUMMARY: FRA is issuing Safety Advisory 2011–02 to remind railroads and their employees of the importance of following procedures when going

between rolling equipment. This safety advisory contains various recommendations to railroads to ensure that these issues are addressed by appropriate railroad operating policies and procedures, and to ensure that those policies and procedures are effectively implemented.

FOR FURTHER INFORMATION CONTACT: Ron Hynes, Director, Office of Safety Assurance and Compliance, Office of Railroad Safety, FRA, 1200 New Jersey Avenue, SE., Washington, DC 20590, telephone (202) 493–6404; or Joseph St. Peter, Trial Attorney, Office of Chief Counsel, FRA, 1200 New Jersey Avenue, SE., Washington, DC 20590, telephone (202) 493–6047.

SUPPLEMENTARY INFORMATION: The overall safety of railroad operations has improved in recent years. However, recent fatal events highlight the need for the railroad industry to refocus its attention on compliance with safety rules and procedures that apply to employees who, in the course of their work, place themselves between rolling equipment. The railroad industry has long recognized that employees whose responsibilities necessitate physically placing themselves between rolling equipment, as often occurs during switching operations, must take adequate safety precautions and be alert and aware of their surroundings at all times. Consequently, railroads developed rules and procedures designed to ensure the safety of employees when between rolling equipment.

In 1998, the industry recognized a troubling increase in the number of employee fatalities occurring during switching operations, including incidents of employees effectively being crushed between rolling equipment. At FRA's request, a voluntary group comprised of industry stakeholders was formed to examine and address that trend of increasing deaths. The group included representatives from the Association of American Railroads (AAR), the American Short Line and Regional Railroad Association (ASLRRA), the Brotherhood of Locomotive Engineers and Trainmen (BLET), the United Transportation Union (UTU), and FRA. The group was later named the Switching Operations Fatality Analysis (SOFA) Working Group. In October 1999, the Working Group issued a report titled ''Findings and Recommendations of the SOFA Working Group.'' The report can be found on FRA's Web site at *http://www.fra.dot.gov/Pages/1781.shtml.*[1] The report contains five major findings with an accompanying recommendation and discussion for each finding. The first of these five recommendations is directly applicable to situations where employees go between rolling equipment, or otherwise foul track or equipment. That recommendation reads as follows:

> Any crew member intending to foul track or equipment must notify the locomotive engineer before such action can take place. The locomotive engineer must then apply locomotive or train brakes, have the reverser centered, and then confirm this action with the individual on the ground. Additionally, any crew member that intends to adjust knuckles/drawbars, or apply or remove EOT device, must insure that the cut of cars to be coupled into is separated by no less than 50 feet. Also, the person on the ground must physically inspect the cut of cars not attached to the locomotive to insure that they are completely stopped and, if necessary, a sufficient number of hand brakes must be applied to insure the cut of cars will not move.

Many railroads have procedures similar to those described in this SOFA recommendation, and other railroads have adopted or modified their procedures to be utilized when going between rolling equipment to reflect this recommendation.

When the pre-SOFA, 9-year period (1992–2000) is compared with the post-SOFA, 9-year period (2001–2009), the industry realized a 60-percent reduction (15 vs. 6) in the number of employees killed when working between rolling equipment. Unfortunately, this positive trend has not continued. Within the last 10 weeks, the railroad industry has experienced three employee fatalities that have occurred when employees were between rolling equipment. In addition to these most recent fatalities, over the last 2 years, two additional employee fatalities have occurred when employees were between rolling equipment. This rise in employee fatalities as a result of being crushed between rolling equipment suggests a need to remind railroads and their employees of the critical importance of maintaining and abiding by railroad rules and procedures designed to ensure safety when going between rolling equipment.

The following is an overview of the circumstances surrounding these recent fatal incidents. Information regarding the three most recent incidents is based on FRA's preliminary investigation findings as the probable causes and or contributing factors of these incidents have not yet been established. Accordingly, nothing in this safety advisory is intended to attribute a definitive cause to these incidents, or place responsibility for the incidents on the acts or omissions of any person or entity.

Recent Incidents

- The most recent incident occurred on September 8, 2011. At approximately 5:15 a.m., a single helper locomotive had coupled to the rear of a standing 125-car train with the intent of assisting the train's movement up an ascending grade. At some point, the movement stopped and the conductor of the single helper locomotive detrained and separated his locomotive from the train he and his engineer had assisted. After the separation, the conductor of the single helper locomotive reattached the end of train device to the last car of the assisted train, and announced to the crew of that train that he had finished his tasks. He then began to walk back to his locomotive. Shortly thereafter, the slack on the assisted train adjusted and the conductor was crushed between the rear car of the assisted train and his locomotive. The deceased was 59 years old with 5 years of railroad experience.
- On August 15, 2011, at approximately 1:30 p.m., a three-person remote control locomotive (RCL) crew consisting of a foreman, a helper, and a trainee entered a track in a bowl yard from the east and coupled onto a cut of cars. The foreman and the trainee boarded the locomotive to provide point protection and the helper, using his remote control transmitter, began stretching the cars eastward to identify gaps created by uncoupled blocks of cars. As the gaps were revealed, the helper repeatedly entered the space between the blocks of cars and made adjustments to knuckles and/or drawbars. Using his remote control transmitter, he then shoved the cars attached to the locomotive westward to couple the cars before continuing the process. The last time the helper went into a gap to adjust the knuckles and/or drawbars, the cars attached to the locomotive moved west and crushed the helper between the cars being coupled. The deceased was 52 years old and had approximately 17 years of railroad experience.
- On July 25, 2011, at approximately 12:30 a.m., a two-person RCL operation had shoved into a classification track and coupled to the westernmost car on the track. The RCL conductor on the crew was creating gaps in the cuts of cars (by pulling west) to adjust couplers

[1] More recently, in March 2011, the SOFA Working Group issued a report titled ''Findings and Advisories of the SOFA Working Group,'' available online at: *http://www.fra.dot.gov/rrs/pages/fp_Findings%20and%20Advisories.shtml.*

and/or align drawbars with the intent of coupling the entire track of 28 cars and pulling it from the classification track. The conductor's helper was riding on the locomotive to provide point protection. The grade on the track was descending from east to west. During one such operation, when the conductor opened a gap, the cars standing to the east of him rolled westward into the cars attached to the locomotive, crushing the conductor. The deceased was 33 years old and had approximately 3½ years of railroad experience.

• On July 13, 2010, at approximately 1:30 a.m., a switching crew was performing a conventional flat, switching operation on a lead track. After separating a cut of cars, the conductor entered the space between the cars attached to his locomotive and those that he had just cut away from in order to make an adjustment to a coupler. He was crushed between the cars still attached to his locomotive and the cut of cars the crew had just cut away from. The deceased was 35 years old and had approximately 6 years of railroad experience.

• On May 10, 2009, at approximately 6:40 p.m., a remote control locomotive operator (RCO) was working in a bowl track, coupling railroad cars together for placement on a departure track. The RCO created gaps in the cuts of cars to adjust couplers and/or align drawbars, and then coupled the cars attached to the locomotive to the cars left standing. The RCO also replaced a knuckle on one of the cars he intended to couple. The RCO went in between the cars to adjust the knuckle he had just installed, and was crushed between equipment when the drawbars bypassed. The deceased employee was 33 years old and had approximately 8 years of railroad experience. The National Transportation Safety Board (NTSB) investigated this incident and cited the deceased employee's loss of situational awareness when he stepped between moving equipment in violation of the railroad's safety rules as a probable cause of the incident.

FRA understands that multiple factors typically contribute to fatal events. Three of the five cases outlined above involved remote control locomotive operations, and in all three cases, the fatally injured employee was in control of the movement at the time of the incident. The fact that RCLs were in use in three incidents does not appear to have any bearing on the events. In the 2010 conventional switching incident there appears to have been no radio transmissions made announcing that the employee on the ground was going between cuts of cars. In the most recent event, it appears there may not have been sufficient distance between the rolling equipment the employee went between.

Each of the above described events, however, demonstrate one consistency—the employees involved either did not have enough room or time to avoid the moving equipment, or were unaware that any equipment they were working with was in motion. These incidents suggest that existing railroad rules governing going between rolling equipment may not have been fully complied with, and also potentially indicate a loss of situational awareness by the employees involved, as well as inadequate management oversight of safety rules compliance by employees.[2]

Railroad operating employees work in an environment which is, by nature, often absent direct management oversight. As the above examples indicate, even slight lapses in rules compliance and situational awareness can lead to tragedy. Without a strong sense of personal responsibility for one's own safety, employees can become complacent and a danger to themselves or other crewmembers. A culture of performing each task safely and as instructed in training must be reinforced not only by management, but by senior, more experienced employees as well. Good workplace habits should be passed along, while questionable work practices should be identified and re-evaluated as newer employees are brought into the railroad workforce. At the same time, railroad management must positively reinforce the need for employees to perform their tasks safely and in accordance with established rules and procedures, and as operations change, management must review existing rules and procedures to ensure that the relevant safety risks of the operating environment are addressed, and that employees are appropriately trained. Moreover, railroad management must eliminate the pressures that it places on employees to expedite train and yard movements as such pressures can negatively impact an employee's ability and desire to perform their assigned task safely.

The discussion contained in this safety advisory is not intended to place blame on or assign responsibility to individuals or railroads, but to emphasize the fact that a robust culture of operating and safety rules compliance is everyone's job. Too often, it is not until after an incident has occurred that railroad management, labor, and regulators fully realize that dangerous work habits were formed and those routine behaviors have not been properly addressed. Support from railroad management and peer pressure from fellow employees encouraging individuals to perform each task in a safe manner via the proper procedures will help railroad employees maintain responsibility for their own safety.

Recommended Railroad and Railroad Employee Action: In light of the above discussion, and in an effort to maintain a heightened sense of safety vigilance among railroad employees who place themselves between pieces of rolling equipment, FRA recommends that railroads:

(1) Review current operating and safety rules that specifically address both remote control locomotive and conventional switching operations that require employees to go between rolling equipment, and determine whether those rules provide adequate protection to employees, or need to be updated or revised.

(2) Develop, implement, and monitor sound communication protocols that require employees on multi-person switch crews to notify their fellow crewmembers when the need arises to enter between two pieces of rolling equipment—regardless of whether the employee is the primary RCO or working on a conventional crew.

(3) Review the SOFA Safety Recommendation # 1, *Adjusting Knuckles, Adjusting Drawbars, and installing End of Train Devices,* reproduced above, and communicate its procedures implementing that recommendation to employees working in yards or other locations where the possibility of entering between rolling equipment exists.

(4) Convey to employees that their own personal safety is their responsibility and that railroad management supports and encourages those employees that make safety their number one priority, regardless of their immediate assignment.

(5) Convey to employees that they should encourage fellow employees to perform their tasks safely and in compliance with established railroad rules and procedures.

FRA encourages railroad industry members to take action that is consistent with the preceding recommendations, and to take other complimentary actions to help ensure the safety of the Nation's railroad employees. FRA may modify this Safety Advisory 2011–02, issue

[2] FRA published Safety Advisory 2010–03 (75 Fed. Reg. 63893 (Oct. 18, 2010)), titled ''Staying Alert and Situational Awareness,'' in response to railroad incidents where employees were killed. In addition to the recommendations made in this Safety Advisory 2011–02, FRA encourages railroads to review those recommendations previously made in Safety Advisory 2010–03 as well.

additional safety advisories, or take other appropriate actions necessary to ensure the highest level of safety on the Nation's railroads, including pursuing other corrective measures under its rail safety authority.

Issued in Washington, DC, on October 5, 2011.

Joseph C. Szabo,

Administrator.

[FR Doc. 2011–26283 Filed 10–7–11; 8:45 am]

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