



W-0423 – Derailment near Mount Vernon Square Station – June 9, 2025

Document Purpose:

This WMSC written report on WMATA Metrorail's safety event investigations and review of Metrorail's findings in accordance with the WMSC Program Standard, in conjunction with the attached Metrorail investigation reports that have undergone WMSC staff review and, if necessary, feedback and revision, describes the investigation activities, identifies factors causing or contributing to the safety events, and sets forth ongoing, additional, or upcoming corrective actions and further oversight work (such as inspections and audits) as necessary or appropriate. The WMSC's ongoing oversight during the investigative process, including safety event reporting and verification, participation in investigative interviews, data review, consistent communication with the Metrorail investigations team, and feedback on Metrorail's reports leads to further improvements prior to consideration of the reports by WMSC Commissioners for adoption. The WMSC's safety event investigation oversight assures the sufficiency and thoroughness of Metrorail's investigations. The WMSC Commissioners are considering these documents (the WMSC review and Metrorail's investigation reports) as a unified item for adoption at the Washington Metrorail Safety Commission meeting on April 14, 2026.

WMSC staff recommend adoption of this investigation.

In 2025, there was one derailment reported to the WMSC. As of April 6, 2026, there have been one 2026 derailments reported.

Safety event summary:

On Monday, June 9, 2025, Flatcar 606, being pushed by Prime Mover (PM) 39, derailed after making contact with a derailer on track 3 outside Mount Vernon Square Station. This track, which is also referred to as a pocket track, is a specialized third track located between the two main operating tracks. This infrastructure allows trains to leave the mainline to change direction (turn back/short-line), store trains until they are needed, or stage maintenance equipment. There were no injuries reported. Damaged infrastructure included fractured tie pads, broken concrete, shifted and broken fasteners, and broken loop cable. The investigation into this incident identified training deficiencies related to the use of derailleurs.

Prior to the derailment, a roadway worker in charge requested a red tag power outage in the pocket track. Shortly after, the Equipment Operator of PM 39, which was traveling to the pocket track work location, was given permission by a rail traffic controller in the control center to access the mainline and was instructed to lead a convoy of rail vehicles. PM 39 also had a flagperson aboard to assist with equipment alignment and signal clearance. After arriving at Mount Vernon Square Station on track 1, the Equipment Operator of PM 39 was instructed by the rail traffic controller to hold at signal E01-26. Minutes later, the rail traffic controller gave PM 39 an absolute block to track 3, and later to track 2.

The roadway worker in charge clamped switch 7 in the reverse position and switch 5b in the normal position and was then advised by the rail traffic controller that they may need to clamp the derailer (switch 13). Derailleurs can be clamped to the rail, however, they must be set to the reverse position to allow for vehicle movement and can be hand cranked



by personnel in the field or remotely exercised by a rail traffic controller placing an aux call¹ on the derailer switch. The rail traffic controller then granted the roadway worker in charge permission to have PM 39 move under their instruction. An investigative review of the Advanced Information Management System (AIMS) showed that at 1:49 a.m., switch 5b went out of correspondence. Approximately 10 minutes later, the roadway worker in charge reported to the rail traffic controller that Flatcar 606 had derailed after passing over the derailer. During an investigative interview following the incident, the Flagperson stated that they did not have a clear view of the derailer from their position inside the vehicle's booth. Metrorail policy requires the flagperson to be outside the booth when approaching a switch. Work was stopped at the location, and all appropriate WMATA personnel were notified of the incident. The flatcar was rerailed and transported to Branch Avenue Yard for inspection.

Both the equipment operator and flagperson were removed from service for post-accident toxicology testing. During investigative interviews following the incident, both the rail traffic controller and the roadway worker in charge expressed limited knowledge regarding derailleurs. The rail traffic controller indicated they had not received training on the use of derailleurs, and the roadway worker stated they were not trained on procedures regarding derailleurs in the work zone. A review of rail traffic controller training documents found that there was limited mention of derailleurs. Derailleurs must be set in the reverse position to allow for vehicle movement.

During the event, both the equipment operator and the flagperson reported experiencing radio communication issues due to an increase in traffic and due to a loss of radio signal.

The probable cause and contributing factors leading to this safety event include:

- Failure to follow established written procedures
- Lack of supervisory oversight regarding identification of the derailer and communication of its presence
- Lack/loss of situational awareness
- Lack of training regarding derailer procedures in the field and in the control center
- Radio communication issues

Investigation W-0423 led to specific corrective actions including:

- The flagperson received refresher training on proper rail alignment while units are in pushing mode
- The Roadway Worker Protection Section of the Metrorail Operating Rule book was reviewed.

¹ An auxiliary switch operation is an alternate method of power switch machine operation using independent manual control without setting a route.



Washington Metropolitan Area Transit Authority
Department of Safety
Office of Safety Investigations

FINAL REPORT OF INVESTIGATION A&I E25766

Date of Event:	June 9, 2025
Type of Event:	Derailment
Incident Time:	01:58 Hours
Location:	Mount Vernon Square Station, track 3
Time and How received by Safety:	02:04 Hours – Safety Information Official (SIO)
Washington Metrorail Safety Commission (WMSC) Notification Time:	02:51 Hours
Responding Safety Officers:	Office of Safety Investigations(OSI)
Rail Vehicle:	Prime Mover (PM) 39- Flat Car 606
Injuries:	None
Damage:	Fractured tie pads, broken concrete, shifted and broken fasteners, broken loop cable
Emergency Responders:	Emergency Response Team (ERT)
Safety Universal Data System (SUDS) Number	20250609#127252

Incident Date: June 9, 2025 Time: 01:58 hours
Final Report – Derailment Rev.1
E25766

Drafted By: SAFE 705 – 08/11/2025
Reviewed By: SAFE 703 – 08/12/2025
Approved By: SAFE 707 – 08/12/2025

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Mount Vernon Square Station – Derailment

June 9, 2025

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Abbreviations and Acronyms

AIMS	Advanced Information Management System
AOM	Assistant Operations Manager
ARS	Audio Recording System
CCTV	Closed-Circuit Television
CENV	Office of Vehicle Program Services
CMNT	Office of Car Maintenance
EO	Equipment Operator
IIT	Incident Investigation Team
MICC	Metro Integrated Command and Communications Center
MOR	Metrorail Operating Rulebook
NOAA	National Oceanic and Atmospheric Administration
OM	Operations Manager
PM	Prime Mover
RTC	Rail Traffic Controller
RWIC	Roadway Worker In Charge
SAFE	Department of Safety
SIO	Safety Information Official
SMS	Safety Measurement System
TRST	Office of Track and Structures
WMATA	Washington Metropolitan Area Transit Authority
WMSC	Washington Metrorail Safety Commission

**Washington Metropolitan Area Transit Authority
Department of Safety – Office of Safety Investigations**

Executive Summary

**Note that all times listed are approximate and may contain minor variations due to differences between systems of record. **

On Monday, June 9, 2025, at 01:58 hours, a derailment occurred at Mount Vernon Square Station pocket track involving flat car 606, which was coupled to Prime Mover (PM) 39. An Office of Track and Structures (TRST) work crew was granted track rights on tracks 2 and 3 to perform third rail maintenance. PM 39, pulling flatcar 606, was dispatched from Branch Avenue Yard and entered Mount Vernon Square Station on track 1. The Equipment Operator requested permission from the Metro Integrated Command and Communications Center (MICC) Radio Rail Traffic Controller (RTC) to cross over from track 1 to track 3.

Once on track 3, the Roadway Worker In Charge (RWIC) requested to clamp switch 5B on track 3 and switch 7 on track 2. The Radio RTC contacted the RWIC and instructed them to check the position of switches 5B and 7, ensuring that switch 5B was lying in “Normal position” and switch 7 in “Reverse position” before clamping them. The RWIC was also informed that they may need to clamp switch 13 (Derailer) on track 3.

When the RWIC confirmed the completion of clamping switches 5B and 7 in place, the Radio RTC granted PM 39 permission to proceed to the platform on track 2 at Mount Vernon Square Station. PM 39 was reversing, a push move; when flat 606 made contact with the derailer on track 3. Flat car 606 derailed, causing damage, and switch 5 went out of correspondence.

The derailment caused fractured tie pads, broken concrete, shifted and broken fasteners, and broken loop cable. There were no injuries reported as a result of this event.

The probable cause of the derailment event on June 9, 2025, at Mount Vernon Square Station was due to a lack of knowledge of the functions of the derailer. Specifically, an auxiliary call should have been placed on the derailer prior to the RTC granting the TRST crew permission to work.

Incident Site

Mount Vernon Square Station is an indoor station with a center platform. There are direct fixation tracks, as well as front and rear interlockings. Track 3 is a pocket track with a derailer.

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Field Sketch/Schematics

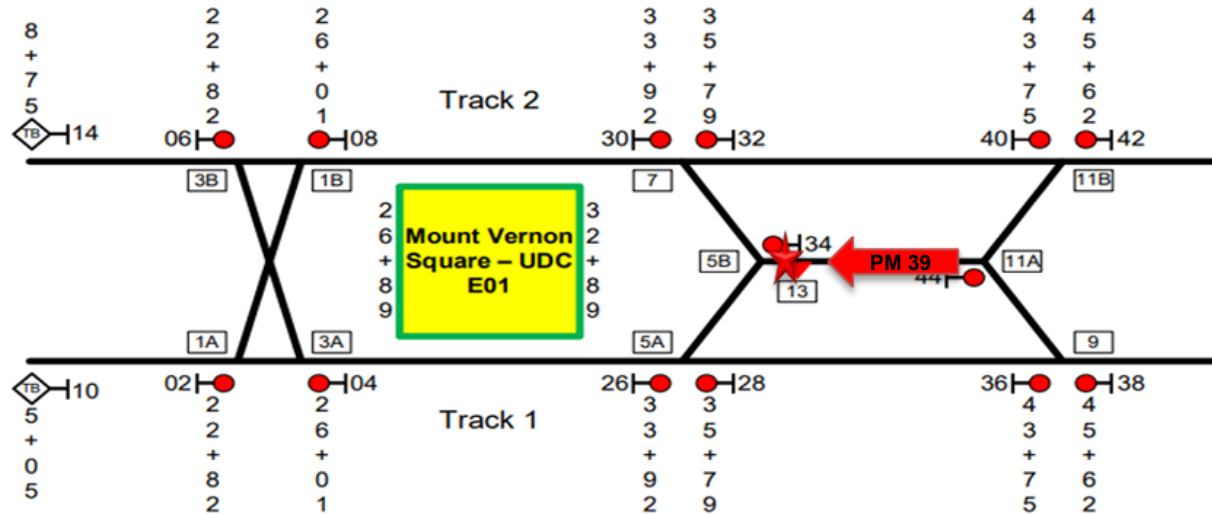


Figure 1 The Red arrow shows the direction of PM39-Flat 606, and the Star indicated the incident location.

Purpose and Scope

The purpose of this accident investigation and candid self-evaluation is to collect and analyze available facts, determine the probable cause(s) of the incident, identify contributing factors, and make recommendations to prevent a recurrence.

Investigative Methods

Upon receiving notification of the Derailment at the Mount Vernon Square Station on June 9, 2025, Safety dispatched a cross-functional team to assess the scene and conduct the subsequent investigation. Safety team members worked with relevant WMATA subject matter experts to review the incident's facts and data.

The investigative methodologies included the following:

- Physical Site Assessment
- Formal Interviews – Safety interviewed five (5) individuals as part of this investigation. The interviews included persons present at, during, and after the incident, those directly involved in the response process, and representatives from the Washington Metrorail Safety Commission (WMSC). Safety interviewed the following individuals:
 - RWIC
 - Equipment Operator
 - Flagman
 - Button RTC
 - Radio RTC

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- Informal Interviews – Collected through conversations with individuals during the investigation to provide background and supporting information. Written statements were reviewed from personnel present during the event.
- Documentation Review – Collection of relevant work history information and process documentation contained in WMATA systems of record. These records include:
 - Training Records
 - Certifications
 - 30-Day work history review
 - Metrorail Operating Rulebook (MOR)
 - National Oceanic and Atmospheric Administration (NOAA)
 - Metro Integrated Command and Communications (MICC) Incident Report
 - Maximo Data
 - CENV Report
 - Oracle
 - RTC Training Guide
- System Data Recording Review – Collection of information contained in Metro Data Recording Systems. This data includes:
 - Audio Recording System (ARS) playback
 - Closed-Circuit Television (CCTV)

Investigation

On Sunday, June 8, 2025, at 22:54 hours, the RWIC contacted the Radio RTC via radio Ops. 3. The RWIC requested a red tag power outage for tracks two and three, for protected chain markers E2 025+97 to E2 050+30 and E3 036+27 to E3 043+27 with PM 39 coming to the work location from Branch Avenue Yard. The Ops. 3 Radio RTC acknowledged the message and instructed the RWIC to contact the Power Desk and stand by, stand clear, and await further instructions.

On Monday, June 9, 2025, at 00:19 hours, the Equipment Operator (EO) of PM 39 notified the Radio RTC that they were located at signal F11-32 and were requesting a lead to Mount Vernon Square track 2. PM 39 was granted permission to enter the mainline with an absolute block to Southern Avenue Station utilizing track 1. After acknowledging that permission was granted to enter the mainline with the appropriate block, the Radio RTC asked if PM 39 was comfortable leading a convoy block with PM 59, which PM- 9 agreed to do. At that time, PM 59 was added to the convoy block.

For eight minutes, PM 39 and 59 moved as a convoy block until clearing Naylor Road Station.

At 00:46 hours, PM 39 notified the Radio RTC that they were holding on track 1 at Mount Vernon Station. Upon notification, the Radio RTC instructed PM-39 to wait at signal E01-26, which was changing to a red aspect.

At 00:52 hours, the Radio RTC gave PM 39 an absolute block to track 3, clearing E01-34 signal. Two minutes afterwards, PM 39 asked if the message could be repeated, and the Radio RTC repeated the instructions, and PM 39 acknowledged all with a 100% repeat back.

At 01:03 hours, the Radio RTC gave PM 39 an absolute block from track 3 to track 2, Mount Vernon Square Station. At that time, PM 39 verified a lunar aspect at E01-34, moved from track 3 to 2, and held their work location at 01:04 hours.

The Advanced Information Management System (AIMS) revealed that at 01:19 hours, third rail power was de-energized on tracks 2 and 3 at Mount Vernon Square Station.

While PM 39 was on track 2, at Mount Vernon Square Station, the RWIC informed the Radio RTC that switches 7 and 5b needed to be clamped in a reverse position. At 01:37 hours, the Radio RTC asked the RWIC to verify the correct switch position, with switch 7 lying in a reverse position and switch 5b in a normal position. The RWIC confirmed the switches position and the Radio RTC granted permission for the switches to be clamped. While the switches were being clamped, the Radio RTC advised the RWIC that the derailer on track 3 was showing in a normal position and that they may need to clamp the derailer as well. The RWIC acknowledged being advised of the positioning of the derailer.

At 01:41 hours, the RWIC informed the Radio RTC that switch 7 and 5b were clamped in the normal position and was requesting permission to move PM 39. Upon hearing the incorrect positioning of switch 7, the Radio RTC confirmed that switch 7 was clamped in the reverse position and switch 5b was clamped in the normal position. After positive confirmation of the correct switch positions, the Radio RTC granted the RWIC permission to move PM 39 under their discretion.

During the travel time, the flag person was in the boot located on the flat to assist the EO with push move equipment alignment and signals clearance. The RWIC did not get on the unit on the platform as they were inspecting switch alignment as the unit moved.

AIMS revealed that at 01:49 hours switch 5b went out of correspondence.

At 01:58 hours, the RWIC contacted an Office of Car Maintenance (CMNT) Controller to report that flatcar 606, which was attached to PM 39, derailed at Mount Vernon Square pocket track after passing over the derailer while moving in the reverse direction near E01-34 signal.

At 02:03 hours, the CMNT Controller informed the MICC Operations Manager (OM) of the reported derailment at Mount Vernon Square pocket track. At 02:04 hours, the OM notified the Safety Information Official (SIO) of the derailment at Mount Vernon Square pocket track.

At 02:13 hours, the Radio RTC informed the RWIC that their work was being placed on delay due to the ongoing investigation and asked if damage had been observed to the infrastructure.

The RWIC reported that no damages to switches, equipment, or tracks were observed; the only damage was to the concrete from where the rear wheels of flatcar 606 derailed, yet it would not affect revenue service.

At 03:43, the flatcar was rerailed without incident and transported back to Branch Avenue Yard.

During a formal interview, the Button RTC stated that they had no knowledge of, nor had they ever been trained on how to deactivate a derailer. RTC training documents on derailers were reviewed and it was identified that it only mentions a derailer being used as a physical barrier. The RWIC was unaware of the derailer at this location and had no training on what to do with a derailer in their work zone.

Upon review of the Oracle report, the pocket track derailer (switch 13) has a timer configuration that is intended to prevent trains from rolling onto the mainline by calling the derailer (switch 13) to normal position which means the metal piece is on the running rail to derail a vehicle, after a train has occupied the pocket track for 5 minutes, except if an AUX (an auxiliary switch operation is an alternate method of power switch machine operation using independent manual control without setting a route) call was placed. The device uses a derail block on top of the running rail when in the "normal" position to force wheels off the rail. WMATA's derailers are numbered switches in a route and are controlled by switch machines. The derailer must be in the "reverse" position, (i.e. in the cradle) to pass a train either direction through a route associated with its nearest signal or nearest track switch. The derailer can be hand cranked but cannot be clamped like a switch. Analysis of the AIMS data showed that there were no AUX calls placed during the routing sequence.

At 04:53 hours, third rail power was reenergized on Tracks 2 and 3 at Mount Vernon Square Station, with switches 7 and 5 being clamped, permitting traffic to enter Track 3. The Equipment Operator and Flagman were removed from service following the derailment.

Chronological Event Timeline

A review of ARS playback, i.e., phone and radio communications, revealed the following timeline:

Time	Description
22:54:52 hours	<u>RWIC</u> : Contacted the Radio RTC to request a Red Tag Outage for Track 2 and 3, for Protected Chain Marker E2 025+97 to E2 050+30 and E3 036+27 to E3 043+27. PM 39 was coming from Branch Avenue Yard (F99) to Mount Vernon Square Station, track 2. <u>Radio RTC</u> : Acknowledged the message with 100% repeat back, gave the RWIC a request time of 22:55 hours, and instructed the RWIC to contact the Power Desk and to stand by and stand clear. [OPS 3 Radio]
00:19:01 hours	<u>PM 39</u> : Announced they were at F11-32 signal requesting a lead onto the mainline en route to Mount Vernon Square Station, track 2. <u>Radio RTC</u> : Acknowledged the message and instructed PM 39 to stand by. [OPS 3 Radio]
00:20:48 hours	<u>Radio RTC</u> : Gave PM 39 an absolute block to Southern Avenue Station, Track 1. <u>PM39</u> : Acknowledged the message with 100% repeat back. <u>Radio RTC</u> : Asked PM 39 if they would lead a convoy block with PM 59. <u>PM39</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]
00:23:44 hours	<u>Radio RTC</u> : Added another unit to the convoy block to Southern Avenue Station, Track 1, with PM39 as the lead unit. <u>PM39</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]
00:25:45 hours	<u>PM39</u> : Announced they had cleared Suitland Avenue Station, Track 1. [OPS 3 Radio]
00:28:45 hours	<u>PM39</u> : Announced they had cleared Naylor Road Station, Track 1. [OPS 3 Radio]
00:30:12 hours	<u>Radio RTC</u> : Informed PM 39 that they were now moving as a single unit with an absolute block to Navy Yard Station, Track 1. <u>PM39</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]

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Time	Description
00:33:36 hours	<u>PM39</u> : Announced they cleared Congress Heights Station, Track 1. [OPS 3 Radio]
00:34:59 hours	<u>Radio RTC</u> : Gave PM 39 an absolute block to Waterfront Station, Track 1. <u>PM39</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]
00:40:09 hours	<u>PM39</u> : Stated they were holding at Waterfront Station, Track 1. <u>Radio RTC</u> : Gave PM39 an absolute block to Mount Vernon Square Station, Track 1. <u>PM39</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]
00:44:00 hours	<u>PM39</u> : Announced they cleared Archives Station, Track 1. [OPS 3 Radio]
00:46:22 hours	<u>PM39</u> : Stated they were holding at Mount Vernon Station, Track 1. <u>Radio RTC</u> : Acknowledged the message with 100% repeat back and instructed PM39 to wait at signal E01-26, which was changing to a red aspect. <u>PM39</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]
00:52:10 hours	<u>Radio RTC</u> : Gave PM39 an absolute block to Track 3 clearing signal E01-34. [OPS 3 Radio]
00:54:28 hours	<u>PM39</u> : Asked Central to repeat their message. <u>Radio RTC</u> : Gave PM39 an absolute block to Track 3 clearing signal E01-34. <u>PM39</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]
00:56:40 hours	<u>PM39</u> : Stated they cleared signal E01-34. <u>Radio RTC</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]
01:00:10 hours	<u>PDAS</u> : Gave the PDC five (5) tags to include 2025160517-A from E01 Tie Breaker to E02 Tie Breaker on Track 1 and E01 Traction Power on Track 3 for the Red Tag outage at Mount Vernon Square Station. [MICC Power Supt Phone]
01:03:12 hours	<u>Radio RTC</u> : Gave PM39 an Absolute Block to cross from Track 3 to Track 2 at Mount Vernon Square Station. <u>PM39</u> : Verified a lunar aspect at E01-34, crossing from Track 3 to Track 2. [OPS 3 Radio]
01:04:52 hours	<u>PM39</u> : Stated that they are holding their work location on Track 2 at Mount Vernon Square Station. <u>Radio RTC</u> : Acknowledged the message with 100% repeat back. [OPS 3 Radio]
01:19:14 hours	Third Rail Power was deenergized on Tracks 2 and 3. [AIMS]
01:35:38 hours	<u>RWIC</u> : Informed the Radio RTC that they needed to clamp switches E01-7 and E01-5B in reverse. <u>Radio RTC</u> : Acknowledged the message and asked the RWIC to confirm all personnel were clear for switch movement. <u>RWIC</u> : Acknowledged that all personnel were standing by and standing clear of the switches. [OPS 3 Radio]

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Time	Description
01:37:03 hours	<u>Radio RTC</u> : Asked the RWIC to verify that switches E01-7 was laying in the reverse position and E01-5B was laying in the normal position. <u>RWIC</u> : Acknowledged and requested permission to clamp the switches. <u>Radio RTC</u> : Granted the RWIC permission to clamp the switches. [OPS 3 Radio]
01:37:33 hours	<u>Radio RTC</u> : Informed the RWIC that the derailer on Track 3 was showing in the normal position and advised the RWIC that they may need to clamp the derailer as well. <u>RWIC</u> : Acknowledged the message. [OPS 3 Radio]
01:41:38 hours	<u>RWIC</u> : Informed the Radio RTC that switches E01-7 and E01-5B were clamped in the normal position and requested permission to move PM39. <u>Radio RTC</u> : Asked the RWIC to confirm that switch E01-7 was clamped in the reverse position and switch E01-5B was clamped in the normal position. <u>RWIC</u> : Confirmed that switch E01-7 was clamped in the reverse position and switch E01-5B was clamped in the normal position. <u>Radio RTC</u> : Acknowledged and gave the RWIC permission to move PM39 at the RWIC's discretion. [OPS 3 Radio]
01:49:29 hours	Switch E01-5A and 5b out of correspondence while blocked. [AIMS]
01:58:15 hours	<u>RWIC</u> : Contacted the CMNT Desk Controller to report that flatcar 606 attached to PM39 derailed at Mount Vernon Square pocket track, passing over the derailer while moving in the reverse direction near signal E01-34. <u>CMNT Desk Controller</u> : Acknowledged the message, advised the RWIC that CTEM was being contacted, and instructed the RWIC to inform the Radio RTC of the incident. [Power PDAS 2 Phone]
02:03:14 hours	<u>CMNT Desk Controller</u> : Informed the OM of the derailment at Mount Vernon Station pocket track involving flatcar 606. [Power PDAS 2 Phone]
02:04:31 hours	<u>OM</u> : Notified the SIO of the derailment at Mount Vernon Square Station pocket track. [Rail 1 Phone]
02:04:39 hours	<u>RWIC</u> : Contacted the Button RTC to report that the flatcar attached to PM39 went over a derailer at Mount Vernon Square Station pocket track while the switches were clamped. [Yellow/Green 2 Phone]
02:05:58 hours	<u>Radio RTC</u> : Instructed the RWIC to call them from an ETS telephone. <u>RWIC</u> : Acknowledged the message. [OPS 3 Radio]
02:06:40 hours	<u>RWIC</u> : Contacted the Button RTC to provide information of all personnel involved in the incident. [Yellow/Green 2 Phone]
02:12:05 hours	<u>Radio RTC</u> : Asked PM39 Equipment Operator if they were pushing the flatcar or pulling the flatcar when the incident occurred. PM39: Stated they were pushing the flatcar. <u>Radio RTC</u> : Acknowledged the message. [OPS 3 Radio]
02:13:31 hours	<u>Radio RTC</u> : Informed the RWIC that their work was being placed on "Delay" status due to the ongoing investigation. <u>RWIC</u> : Acknowledged the message. <u>Radio RTC</u> : Asked the RWIC if they observed any damage to equipment or infrastructure. <u>RWIC</u> : Stated they were inspecting the area. [OPS 3 Radio]
02:30:49 hours	<u>RWIC</u> : Contacted the OM and reported that no damage to the switches, equipment, or tracks was observed. Damaged concrete was observed that would not impact revenue service. The RWIC explained that the rear

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Time	Description
	wheels of flatcar 606 derailed, and the front wheels remained on the tracks. [Rail 1 Phone]
02:36:00 hours	<u>ATCM</u> : Asked the Radio RTC for permission to speak directly with the RWIC to get permission to enter their work location to inspect the derailer. <u>Radio RTC</u> : Acknowledged the message. <u>RWIC</u> : Acknowledged the message and granted the ATCM permission to enter their work location. [OPS 3 Radio]
03:43:00 hours	Flatcar 606 successfully rerailed.
04:53:00 hours	Third rail power was reenergized on Tracks 2 and 3 Mount Rainer [AIMS]

Note: Times above may vary from other systems' timelines based on clock settings.

Advanced Information Management System (AIMS)

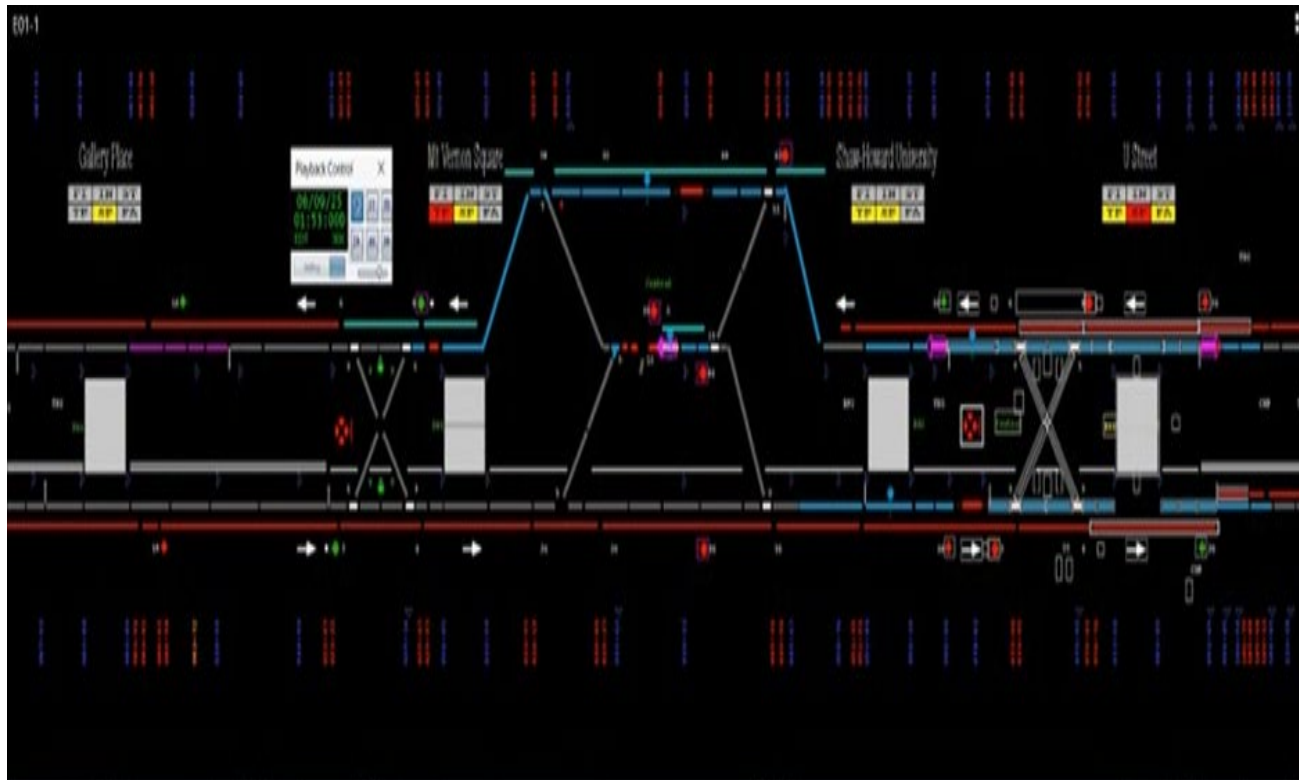


Figure 2 PM39 and Flatcar 606 occupying the circuit in Track 3, Mount Vernon Square Station.

Office of Vehicle Program Services (CENV)

On the morning of June 9, 2025, at approximately 0150 hours, Flat Car F606, being pushed in reverse by PM39, derailed its leading (B-end) truck exiting the Mount Vernon pocket track. The derailment caused minor damage to the flatcar and infrastructure. No injury to personnel was reported. Investigation revealed the cause of the incident to be the B-end of F606 traversing automatic derailer 13. [Appendix B: CENV Incident Report F606 Derailment](#)

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Interview Findings and Written Statements

As part of the investigation launched into the event, Safety interviewed five people. The interviews identified the following key findings associated with this event. The findings detailed below include reported information from involved personnel and may conflict with other data sources contained in the report.

RWIC

- PM 39 was used to set up the work area.
- General Orders and Track Rights System (GOTRS) did not specify anything about a derailer in the work area.
- The MICC mentioned a derailer.
- This was the first time dealing with a derailer from track 3 to track 2 at Mount Vernon Square Station.
- ATC was there to support due to an issue with the third rail.

Equipment Operator

- At the time of the derailment, the movement of PM 39 was under the direction of the RWIC.
- The original work location was only track 2, and the supervisor extended the work location.
- The flat was being pushed when it derailed.
- Briefing was done inside the unit before the work area was set up. No mention of a derailer while doing the briefing.
- Hard to communicate with the flagman due to continuous communication with other units.

Flagman

- From the location in the booth, the flagman did not have a clear view of the area.
- The movement before the derailment signal at E01-34 had a red aspect
- The radio was saying out of range at the time of the derailment.

Radio RTC

- Once ETO is granted, the location is under the RWIC's control.
- The entire interlocking wasn't clamped because lunars could still be established on track 1.

Button RTC

- This was the first time working with a crew in Mount Vernon Pocket track.
- Although they had knowledge of the derailer in the pocket track, they were never trained how to deactivate or control a derailer.

Weather

On June 9, 2025, at the time of the incident, NOAA recorded the temperature as 68°F, with clear skies, winds 6 mph, and 99% humidity. Weather was not a contributing factor in this incident (Weather source: NOAA) – Location: Washington, DC

Related Rules and Procedures

MOR 17.20

Contains a procedure to establish IT using a physical barrier. There are different procedures for establishing IT with or without a derailer. Whether a derailer is used or not does not change the steps for the RTC, it only changes the configuration of the equipment on the roadway for the RWIC

MOR8.2.1

Movement made at Restricted Speed must apply all three (3) of the following requirements as a method of operation:

1. Control the movement to permit stopping within half (1/2) the range of vision short of:
 - a. Other trains or railroad equipment occupying or fouling the track,
 - b. Obstructions on or fouling the track,
 - c. Switches not properly lined for movement,
 - d. Derails set in the derailing position,
 - e. Employees working in the foul of the track,
 - f. The end of track,
 - g. Any signal requiring a stop.
2. Looking out for broken rail and misaligned track
3. Do not exceed 15 mph. This restriction applies to the entire movement, unless otherwise specified in the rule or instruction that requires Restricted Speed.

Human Factors

Evidence of Fatigue

SAFE examined signs and symptoms of fatigue that may have been present at the time of the incident. No video of the involved person was available to ascertain whether signs of fatigue were present. The Equipment Operator reported feeling fully alert at the time of the incident. The Equipment Operator reported experiencing no symptoms of fatigue in the time leading up to the incident.

Fatigue Risk

SAFE evaluated incident data for fatigue risk factors. No significant risk was identified. The incident time of day did not suggest an increased risk of fatigue-related impairment. The Equipment Operator reported keeping a regular sleep schedule in the days leading up to the incident. The Equipment Operator worked night shift in the days leading up to the incident. The Equipment Operator was awake for 5.96 hours at the time of the incident. The Equipment Operator reported 5 hours of sleep in the 24 hours preceding the incident. The off-duty period was sixty-four hours which provides an opportunity for 7-9 hours of sleep. This was a comparable amount than the Equipment Operator's usual workday sleep durations. The Equipment Operator reported no issues with sleep.

Post-Incident Toxicology Testing

WMATA's Drug and Alcohol Program determined that the EO Involved complied with were not in violation of the Drug and Alcohol Policy and Testing Program 7.7.3/6.

Findings

- Failure by personnel to identify that the derailer on Track 3 remained in the Normal position during movement authorization.
- Breakdown in communication between the Roadway Worker In Charge (RWIC) and Rail Traffic Control (RTC) regarding the status and confirmation of derailer clamping.
- The automatic derailer functioned as manufactured and reset after the circuit in the third track had been occupied for five minutes.
- Both TRST and the Radio RTC did not identify that the derailer on track 3 remained in the normal position during movement authorization.
- PM39 was pulling flatcar 606 when entering track 3 at Mt. Vernon Square
- PM39 was used to set up the work area, which caused PM39 to push flatcar 606 from the pocket track.
- ATC was on location but not for support to this work crew.
- The Flagman was located in the flatcar booth and should have identified the derailer sign on the wall in the pocket track.

Immediate Mitigation to Prevent Recurrence

- The Flagman and the PM39 Operator were removed from service and subjected to post-incident testing under standard safety protocols.
- PM39 and flat 606 were secured and preserved at the incident scene to support ongoing investigation and evidence collection.

Probable Cause Statement

The probable cause of the derailment event on June 9, 2025, at Mount Vernon Square Station was due to a lack of knowledge of the functions of the derailer. Specifically, an auxiliary call should have been placed on the derailer prior to the RTC granting the TRST crew permission to work.

Recommended Corrective Actions

Corrective Action Code	Description	Responsible Party	Estimated Completion Date
127252_SAFE_CAPS_TRST_001	The Flagman will complete refresher training on proper rail alignment while units are in a pushing mode.	TRST	Completed
127252_SAFE_CAPS_OOP_001	The RWP section of the MOR will be reviewed to determine if derailleurs need to be incorporated for work zone setups.	OOP	Completed

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Final Report – Derailment Rev.1
E25766

Drafted By: SAFE 705 – 08/11/2025
Reviewed By: SAFE 703 – 08/12/2025
Approved By: SAFE 707 – 08/12/2025

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Appendices

Appendix A – Interview Summaries

The below narratives summarize the incident and represent the statements made by the involved individual. As such, times and details may present a conflict with the data contained in systems of record.

RWIC

The Roadway Worker In Charge (RWIC) is a Track Supervisor and a WMATA employee with 13 years of service and six years of experience as a RWIC. The RWIC holds a Roadway Worker Protection (RWP) Level 4 certification, which expires in September 2025.

During the interview, the RWIC reported that a toolbox meeting was held at 22:00 hours, during which tasks were assigned to the crew. The team prepared all necessary equipment for the Third Rail Renewal project on Tracks 2 and 3 at Mount Vernon Square Station, including Prime Mover (PM) 39 and Flat Car 606, and then proceeded to the job site.

Upon arrival at Mount Vernon Square, the RWIC contacted the Metro Integrated Command and Communications Center (MICC) Rail Traffic Controller (RTC) to request authorization to establish the work area. The RTC granted permission for hot-sticking and confirmed that third rail power had been de-energized. After the RWIC verified that the power was indeed de-energized, the RTC issued authorization to place track shunts and mats. PM 39, coupled with Flat Car 606, was used to expedite this setup process.

The crew initially staged on Track 3, the outbound side at Mount Vernon Square. To reposition the consist back to the platform via Track 2, the RWIC contacted the RTC to request clamping of Switch 5B on Track 3 in the “Normal position” and Switch 7 on Track 2 in the “Reverse position.” The RTC granted permission, confirming and repeating the intended switch positions to ensure accuracy and operational safety.

The RWIC acknowledged that all affected switches had been properly clamped to secure safe movement. They further noted that the GOTRS did not indicate the presence of fixed derailleurs, which is typical, as such elements are usually not listed in the GOTRS documentation. The RWIC also recalled the RTC referencing a derailer in the area, although they did not anticipate any issues arising from it, stating that derailer-related problems generally do not occur when switches are correctly clamped.

Equipment Operator

The Equipment Operator (EO) is a WMATA employee with 2 years of service and 2 years of experience as an EO. The EO holds a Roadway Worker Protection (RWP) Level 2 certification that expires in August 2025.

During the interview, the EO reported that their initial assignment was on track 2 at Mount Vernon Square on the night of the incident; however, their supervisor subsequently expanded the assignment to include tracks 2 and 3.

The EO traveled aboard PM 39, coupled with Flat 606, on track 1 to Mount Vernon Square Station. They had received authorization from the MICC RTC to crossover from track 1 to track 3. Once on track 3, the EO maneuvered the consist back to the platform via track 2, where the TRST crew

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was assembled. At that time, the RWIC had permission to establish the work zone and had set up at the lower end of the platform on the inbound side of track 2.

Following this, the RWIC directed the EO to return to track 3 to assist in setting up the outbound work zone on tracks 2 and 3. The crew rode the PM 39 coupled with Flat 606 from the platform to track 3 in pulling mode. Once positioned on track 3, the RWIC installed shunts and lanterns as part of the work zone set up at the outbound end of the station, oriented toward Shaw-Howard University Station.

Prior to PM 39 and Flat 606 returning to track 3, the RWIC coordinated with RTC to clamp switches in the Reverse position, allowing access to track 3 via track 2. After the setup was complete, the RWIC requested to return to the platform via track 2. During this movement, with PM 39 pushing Flat 606, the consist encountered an engaged derailer, resulting in a derailment.

The EO stated that while traveling in pull mode outbound to establish the work area, they observed the derailer sign. However, on the return trip to the platform on track 2, traveling in push mode, they did not realize the derailer was engaged.

The EO also indicated limited knowledge regarding derailer functionality.

Flagman

The Vehicle Flag-Person (VFP) is a Track Repairer D and is a WMATA employee with 1 year of service and 1 year of experience as a VFP. The VFP holds a Roadway Worker Protection (RWP) Level 2 certification that expires in May 2026.

During the interview, the Vehicle Flag Personnel (VFP) reported that they initially arrived at Mount Vernon Square on Track 1. They then maneuvered Prime Mover (PM) 39, which was coupled with Flat Car 606, to Signal 34 located on Track 3 within the pocket track. Upon passing Signal 34, they staged the consist on Track 3. At this point, the Roadway Worker In Charge (RWIC) contacted the Metro Integrated Command and Communications (MICC) Rail Traffic Controller (RTC) to request that the track switch machines be clamped in the "Reverse position" to facilitate the movement of PM 39 back to the platform via Track 2. The RTC granted authorization to clamp the switches accordingly.

Following the switch clamping, the RTC issued movement authority to the EO of PM 39. The EO sounded the horn as a standard audible signal indicating the commencement of movement. The consist - PM 39 and Flat 606 - then began traveling in reverse toward the platform on Track 2, with the VFP positioned in the operator's control box aboard Flat 606.

While executing the reverse movement, Flat 606 encountered an engaged fixed derailer on Track 3. This resulted in the flat car derailing from the track. The VFP clarified that during the reverse movement, the RWIC had already secured control of the designated work area and had authorized the movement. Signal 34 was displaying a red aspect at the time.

The VFP also reported experiencing intermittent radio communication issues in the area, describing "dead spots" where the radio system displayed an "out of range" status. Additionally, the VFP confirmed having received a Roadway Job Safety Briefing (RJSB) before accessing the roadway. However, they did not recall any mention of the presence or location of fixed derailleurs during the briefing.

Radio RTC

The Radio Rail Traffic Controller (RTC) is a WMATA employee with 3 years of service and 3 years of experience as an RTC. The radio RTC holds a Roadway Worker Protection (RWP) Level 4 certification that expires in March 2026

During the interview, the Radio RTC reported that they were working as the Radio RTC on the day of the derailment at Mt. Vernon Square with Flatcar 606. The Radio RTC stated that the unit came out of the yard and got to the work location at Mt. Vernon Square. The work location was for Mt. Vernon Square Tracks two and three. ETO was granted for Track 2 and 3 TRST was placing shunts and hot sticking, then the RWIC stated they wanted to place the unit in Track 3 inside the work location. Switch 7 would need to be placed in reverse, and switch 5b was in a normal position once confirmation was given that everyone was standing by, standing clear. The buttons RTC threw the switch on 7, and the RWIC stated they were clamping the switches. Once both switches were clamped, the Radio RTC stated that they advised the RWIC of the derailer that was within the pocket and that it may need to be clamped, which was confirmed.

The Radio RTC stated that once ETO is granted, the location is the RWICS, the entire interlocking was not clamped because lunar signals could still be established on Track 1.

Buttons RTC

The Buttons Rail Traffic Controller (RTC) is a WMATA employee with 3 years of service and 2 months of experience as an RTC. The radio RTC holds a Roadway Worker Protection (RWP) Level 4 certification that expires in November 2025.

During the interview, the radio RTC reported that at the time of the derailment, they were working with a Radio RTC person. This was the first time the Buttons RTC worked with a crew working within Mt. Vernon Pocket track. Although the Buttons RTC knew there was a derailer in the pocket track, but was never trained or told that there was anything they could do to deactivate or control the derailer.

The Buttons RTC stated that they heard the Radio RTC instruct the RWIC to clamp the derailer, but do not know if the RWIC acknowledged what was being said.



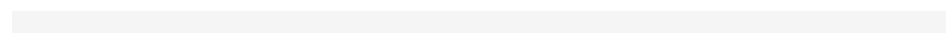
Washington Metropolitan Area Transit Authority

CENV

Incident Report

F606 Derailment

June 11, 2025



Incident Date: June 9, 2025 Time: 01:58 hours
Final Report – Derailment Rev.1
E25766

Drafted By: SAFE 705 – 08/11/2025
Reviewed By: SAFE 703 – 08/12/2025
Approved By: SAFE 707 – 08/12/2025



Washington Area Metropolitan Transit Authority
Incident Summary Report

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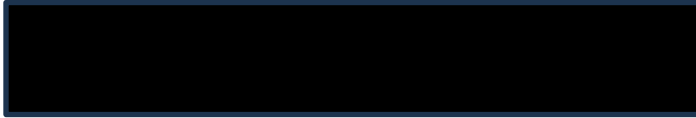
LOCATION: Pocket Track E01 CM 36+37

INCIDENT #: N/A

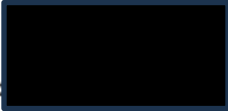
DATE: June 9th, 2025

TIME: 0200

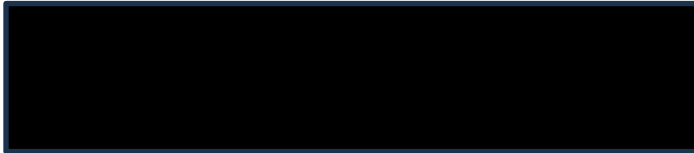
Investigation Team Members



Report Prepared By:



Report Approved By:



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Executive Summary

On the morning of June 9th, 2025, at approximately 0150 hours, Flat Car F606, being pushed in reverse by PM39, derailed its leading (B-end) truck exiting the Mt. Vernon pocket track (Figure 1). The derailment caused minor damage to the flatcar and infrastructure. No injury to personnel was reported.



Figure 1. Derailed F606, concrete damage

Investigation revealed the cause of the incident to be the B-end of F606 traversing automatic derailer 13.

Findings of Investigation

At approximately 0150 hours on the morning of June 9th, 2025, at the E01 (Mt. Vernon Square station) pocket track, the MICC was notified of a derailment in which the leading truck of F606 traversed a derailer during a reverse move. MICC also reported Switch 5 and Derailer 13 at Mount Vernon Square Pocket Track displaying out of correspondence.

Information from the onboard data logger was retrieved and graphed (see Figure 2), allowing the following timeline of events to be constructed. Note that the datalogger internal time clock measures 18 minutes behind local time.

- 01:31(49):17 – Service brake is released, and PM39 consist begins reverse move.
- 01:31(49):24 – Consist reaches a speed of 4 mph and encounters derailer.
- 01:31(49):26 – Consist begins decelerating as leading truck derails.
- 01:31(49):27 – Service brake application is initiated. Brake pipe pressure remains steady.
- 01:31(49):30 – Consist comes to rest approximately 36 feet after derailing. Train brake application is initiated.

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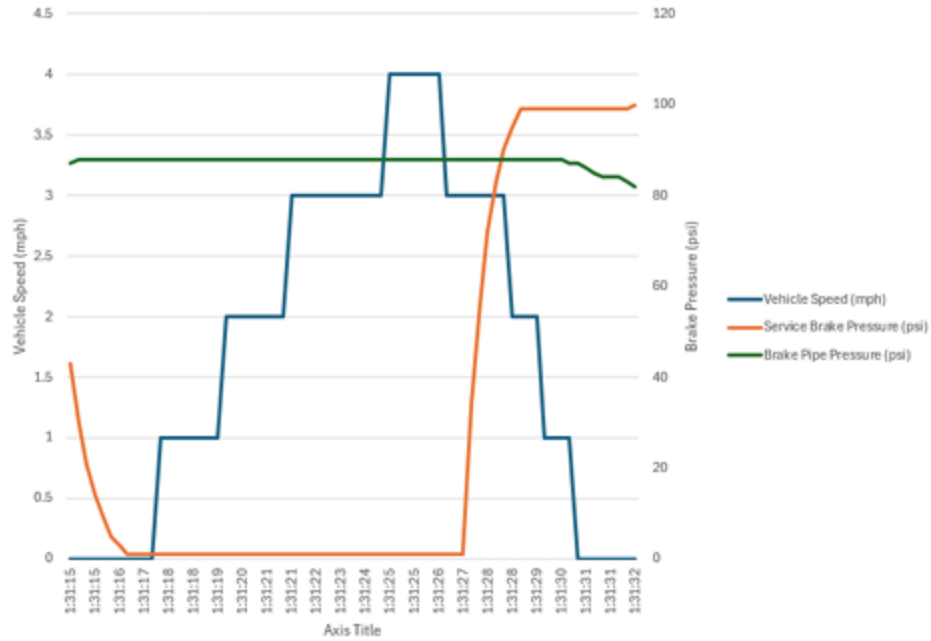


Figure 2. Graphical timeline of incident.

Post-incident inspection of F606 by CTEM revealed damage to the rear truck center pivot bowl caused by the vertical separation of the chassis from the truck and subsequent misalignment upon return (see Figure 3). No notable deficiencies were noted on PM39 or F606 that would have contributed to this incident.



Figure 3. Circumferential damage to center pivot bowl

Conclusion

Investigation revealed the cause of the incident to be the rear truck traversing automatic derailer 13.

Recommendations

- Repair the rear truck bowl of F606 per WPS AAR-CPL-S308
- CENV does not recommend any changes to equipment configuration

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Appendix C – Oracle Report

	Washington Metropolitan Area Transit Authority	
	INVESTIGATION REPORT	FORM: INFR-COSI-ATCE-INCIDENT ANALYSIS PM 39-Flat 606 Derailment – E01 (Pocket Track)

EXECUTIVE SUMMARY:

WMATA-SAFE requested Oracle (AIMS) Data for events leading to derailment in the Mt. Vernon (E01) pocket track, adjacent to signal 34, involving work vehicle, Prime Mover (PM39) with a connected flat car 606. The oracle request puts the incident between [00:00:00 to - 05:00].

Analysis of AIMS data showed that on June 09, 2025 at approximately 01:43:01, PM39 travelled in the reversed direction of traffic toward E01.

At 01:36:45 switch 5 was set to Normal, switch 7 set Reverse and switch 13 (derailer) set Reverse. At this time Central aligned a reverse route from signal 30 to 34, into the pocket track.

At 01:43:01, PM39 cleared track circuit E2-33 outside of the E01-2 platform and travelled in the reversed direction of traffic toward signal 30. At 01:43:25, PM39 entered the pocket track by occupying 7AAT, cleared switch 5, track circuits E3-37 and stopped at E3-41 at approximately 01:44:36, fully occupying the pocket track.

By design, pocket track derailer (switch 13) has a timer configuration that is intended to prevent trains from rolling onto the mainline by calling the derailer (switch 13) to normal position after a train has occupied the pocket track for 5 minutes, except an aux call was placed. Analysis of the AIMS data showed that there were no AUX call placed during the routing sequence.

At 01:47:13, PM 39 reoccupied E3-37 and cleared track circuit E3-41, an indicating its movement backward, in the opposite direction of travel toward switches 5B and 13.

At 01:49:06, Switch 13 was called normal and moved into the normal position, an indication that the 5-minute timer expired.

At approximately, 01:49:29, track circuit 5BT was occupied and cleared. At this time, with no indication of switches 13 and 5 control from central, the work vehicle rode over switches 13 which was in its Normal derail position and derailed and forced switch 5 out of correspondence.

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COSI-SIGNAL ENGINEERING	Washington Metropolitan Area Transit Authority		Detailed Incident Analysis					
			Report Num:			[REDACTED]		
			Requestor:			[REDACTED]		
			Date:			June 23, 2025		
			From:			[REDACTED]		
To:			[REDACTED]					
Reported Data:		Time: 01:40		Train ID		PM39		
Description: Derailment		E01-3 (Pocket Track)		Interlocking Control: CENTRAL				
Requested Analysis: Investigate Incident								
INITIAL STATE AS OF: [01:30:45 to 01:36:00]								
Name	STATE	AUTO	NAME	STATE	AUTO	NAME	STATE	AUTO
TWC	ON	-	SW 5	Normal	-	-	-	-
7AAT	Vacant	-	SW 7	Normal	-	-	-	-
SBT	Vacant	-	SW 13	Reverse	-	-	-	-
RECORDED EVENT DATA								
TIME	LOCATION	STATUS/ CONTROL	AIMS DESCRIPTION			COMMENTS		
01:36:45	E01	STATUS	Switch call 5 Call Normal			A normal call is placed on switch 5		
01:36:45	E01	STATUS	Switch Call 7 Call Reverse			A reverse call is placed on switch 7		
01:36:41	E01	Control	Signal 34 Request Route			Central set route through signal 34 and 30 to the pocket		
01:36:42	E01	Control	Signal 30 Request Route					
01:36:45	E01	STATUS	Switch Call 13 Call Reverse			A reverse call is placed on switch 13		
01:36:45	E01	STATUS	Switch Position 5 Normal			Switch 5 is in the normal position.		
01:36:50	E01	STATUS	Switch Position 7 Reverse			Switch 7 is in reverse position		
01:36:51	E01	STATUS	Route Lock Track 5B Locked			Route is locked for entrance into E01 pocket track.		
01:36:51	E01	STATUS	Route Lock Track 7 Locked					
01:36:51	E01	STATUS	Approach 34 Locked			PM39 traverses Track 2 in reverse direction of normal traffic and proceeds into E01 pocket track.		
01:43:01	E01	STATUS	Track Circuit E2-33 Occupied					
01:43:25	E01	STATUS	Track Circuit 7AAT Occupied					
01:43:34	E01	STATUS	Track Circuit 5BT Occupied					
01:43:36	E01	STATUS	Track Circuit E2-33 Vacant					
01:44:01	E01	STATUS	Track Circuit E3-37 Occupied					
01:44:02	E01	STATUS	Track Circuit 7AAT Vacant					
01:44:12	E01	STATUS	Track Circuit 5BT Vacant			PM39 clears 5BT and heads into pocket track		
01:44:36	E01	STATUS	Track Circuit E3-41 Occupied					

Incident Date: June 9, 2025 Time: 01:58 hours
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 E25766

Drafted By: SAFE 705 – 08/11/2025
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 Approved By: SAFE 707 – 08/12/2025



Washington Metropolitan Area Transit Authority

INVESTIGATION REPORT

FORM: INFR-COSI-ATCE-INCIDENT ANALYSIS
PM 39-Flat 606 Derailment – E01 (Pocket Track)

01:45:00	E01	STATUS	Track Circuit E3-37 Vacant	Train clears 7AAT, 5BT and fully occupies the pocket track
01:47:13		STATUS	Track Circuit E3-37 Occupied	Train reoccupied E3-37 and clears track circuit E3-41, indicating trains movement backward, in the opposite direction toward 5BT and 7AAT.
01:47:46	E01	STATUS	Track Circuit E3-41 Vacant	
01:49:01	E01	STATUS	Switch Cell 13 Call Normal	A Normal call status is shown for SW 13
01:49:06	E01	STATUS	Switch Position 13 Normal	Switch 13 is in the Normal position
01:49:27	E01	STATUS	Track Circuit 5BT Occupied	5BT is occupied indicating PM39 continuous movement backwards out of the pocket, toward 7AAT, 5BT.
01:49:28	E01	STATUS	Switch Position 13 Out Of Corresp	Switch leaves out of Normal position and goes out of correspondence.
01:49:29	E01	STATUS	Track Circuit 5BT Vacant	PM39 continues movement in opposite direction. It clears 5BT and Switch 5 goes out of correspondence simultaneously.
01:49:29	E01	STATUS	Switch Position 5 Out Of Corresp	

Circuit Power Failure: Yes No Processor Failure: Yes No Power Transfer: Yes No

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Appendix D – Scene Photographs



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Appendix E – Work Order

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E25766

Drafted By: SAFE 705 – 08/11/2025 Reviewed By: SAFE 703 – 08/12/2025 Approved By: SAFE 707 – 08/12/2025

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**Washington Metropolitan Area Transit Authority
Maintenance and Material Management System
Work Order Details**

Work Order #: 19677590
Type: PCM

19677590

Status: CLOSE
08/23/2025 12:11

Work Description: TKMSE Interlocking Maintenance E01, Track 3

Job Plan Description:

Switch Point, stock rail, and closure rail renewal

		Work Information	
Asset: TEX	E-LINE, TRACK-X EQUIPMENT PARENT	Owning Office: TRST	Parent:
Asset Tag:		Maintenance Office: TRST-TRAK	Create Date: 07/19/2025 08:24
Asset SIN:		Labor Group: TRST-TRAK-BRAN	Actual Start: 07/24/2025 05:58
Location: E	ORIM, E Line, Greenbelt	Crew:	Actual Comp: 08/23/2025 12:11
Work Location:		Lead:	Item:
Failure Class: TRSTRAIL	TRST, RAIL	GL Account: WMATA-02-33660-50499360-042-*****-OPR**	Target Start:
Problem Code: D97	WORK PLAN MULTI DEFECTS (plan wo's only)	Supervisor:	Target Comp:
Requested By: [REDACTED]		Requestor Phone:	Scheduled Start:
Create-Mileage: 0.0		Complete-Mileage: 0.0	

Task IDs						
Task ID						
10	Closure Rail					
<p>Personnel reported to E01 for interlocking maintenance. Personnel removed and installed 1 closure rail measuring at 26 ft 9in at E01 5B LR. Atc reconnected pin bonds and verified track circuits.</p> <p>All work was performed in accordance with WMATA TRST 1000</p>						
Component:	200-R01 RUNNING RAIL	Work Accomp:	INSTALLED	Reason:	SCHEDULED	Status: CLOSE Position: L Warranty?: N
20	Rail Prep					
<p>Personnel reported to E01 for interlocking maintenance. Due to atc not having the proper tools to reconnect jumper cables from closure rail to guarded switch point at E01 5B, new closure rail could not be installed. (Jumper cable is welded onto closure/ switch point)</p> <p>Personnel then measured and prepped closure for tomorrow night by cutting 26ft 9 1/2in piece of rail. Then personnel drilled holes and connected IJ in proper position on closure rail. Closure was then staged alongside track 3 for installation at later date.</p> <p>Atc also came and performed assessment of rail and tools needed to properly reinstall jumper cable to closure rail and guarded switch point.</p> <p>All work was performed in accordance with WMATA TRST 1000</p>						
Component:	200-R01 RUNNING RAIL	Work Accomp:	PREPPED	Reason:	SCHEDULED	Status: CLOSE Position: L Warranty?: N

Incident Date: June 9, 2025 Time: 01:58 hours
Final Report – Derailment Rev.1
E25766

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Reviewed By: SAFE 703 – 08/12/2025
Approved By: SAFE 707 – 08/12/2025



**Washington Metropolitan Area Transit Authority
Maintenance and Material Management System
Work Order Details**

Work Order #: 19677590
Type: PCM

19677590

Status: CLOSE
08/23/2025 12:11

Work Description: TKMSE Interlocking Maintenance E01, Track 3
Job Plan Description:

Task IDs					
Task ID					
30	Core Drill Studs				
<p>Personnel reported to E01 for interlocking maintenance. Personnel first inspected work alongside atc to verify all that was needed to complete job task. From inspection atc verified they didn't have the right bit to reconnect jumper cable at heel block and wouldn't be able to support us and rail could not be replaced. Personnel then went to E01 5B switch and core drilled 4 studs in switch point area. 4 new studs were drilled, glued, and tied down. Personnel also prepped closure rail for E01 5A by cutting one 36ft piece of rail and installing 1 U. Closure rail is now on empty flat ready for whenever it can be installed. All work was performed in accordance with WMATA TRST 1000 Note: Also closure rail for E01 5B was prepped the night before and is ready for install. Rail in holding outside of E01 5B switch</p>					
Component:	200-F06 STUDS	Work Accomp:	REPLACED NEW	Reason:	SCHEDULED
	9001		Level 1 Quality Check	Status:	CLOSE
			Position:	L	Warranty?: N
Component:		Work Accomp:		Reason:	
	9002		Level 2 Quality Check	Status:	CLOSE
			Position:		Warranty?: N
Component:		Work Accomp:		Reason:	
			Work Meets SOP 208-15, all documents attached.	Status:	CLOSE
			Position:		Warranty?: N

Actual Labor										
Task ID	Labor	Start Date	End Date	Start Time	End Time	Approved?	Regular Hours	Premium Hours	Line Cost	
10		07/23/2025	07/24/2025	22:00	06:00	Y	08:00	00:00	\$314.96	
10		07/23/2025	07/24/2025	22:00	06:00	Y	08:00	00:00	\$332.46	
10		07/23/2025	07/24/2025	22:00	06:00	Y	08:00	00:00	\$332.46	
10		07/23/2025	07/24/2025	22:00	06:00	Y	08:00	00:00	\$349.95	
10		07/23/2025	07/24/2025	22:00	06:00	Y	08:00	00:00	\$308.95	
10		07/23/2025	07/24/2025	22:00	06:00	Y	08:00	00:00	\$428.81	
10		07/23/2025	07/24/2025	22:00	06:00	Y	08:00	00:00	\$335.78	
10		07/23/2025	07/24/2025	22:00	06:00	Y	08:00	00:00	\$406.93	
20		07/24/2025	07/25/2025	22:00	06:00	Y	08:00	00:00	\$314.96	
20		07/24/2025	07/25/2025	22:00	06:00	Y	08:00	00:00	\$314.96	
20		07/24/2025	07/25/2025	22:00	06:00	Y	08:00	00:00	\$332.46	
20		07/24/2025	07/25/2025	22:00	06:00	Y	08:00	00:00	\$332.46	
20		07/24/2025	07/25/2025	22:00	06:00	Y	08:00	00:00	\$349.95	
20		07/24/2025	07/25/2025	22:00	06:00	Y	08:00	00:00	\$308.95	
20		07/24/2025	07/25/2025	22:00	06:00	Y	08:00	00:00	\$428.81	

Incident Date: June 9, 2025 Time: 01:58 hours
Final Report – Derailment Rev.1
E25766

Drafted By: SAFE 705 – 08/11/2025 Reviewed By: SAFE 703 – 08/12/2025 Approved By: SAFE 707 – 08/12/2025



Washington Metropolitan Area Transit Authority
Maintenance and Material Management System
Work Order Details

Work Order #: 19677590
Type: PCM

19677590

Status: CLOSE
08/23/2025 12:11

Work Description: TKMSE Interlocking Maintenance E01, Track 3

Job Plan Description:

Actual Labor										
Task ID	Labor	Start Date	End Date	Start Time	End Time	Approved?	Regular Hours	Premium Hours	Line Cost	
20		07/24/2025	07/25/2025	22:00	06:00	Y	08:00	00:00	\$335.78	
30		07/25/2025	07/26/2025	22:00	06:00	Y	08:00	00:00	\$297.46	
30		07/25/2025	07/26/2025	22:00	06:00	Y	08:00	00:00	\$314.96	
30		07/25/2025	07/26/2025	22:00	06:00	Y	08:00	00:00	\$314.96	
30		07/25/2025	07/26/2025	22:00	06:00	Y	08:00	00:00	\$332.46	
30		07/25/2025	07/26/2025	22:00	06:00	Y	08:00	00:00	\$332.46	
30		07/25/2025	07/26/2025	22:00	06:00	Y	08:00	00:00	\$398.95	
30		07/25/2025	07/26/2025	22:00	06:00	Y	08:00	00:00	\$428.81	
30		07/25/2025	07/26/2025	22:00	06:00	Y	08:00	00:00	\$335.78	
Total Actual Hour/Labor:							192.00	00.00	\$8,464.43	

Failure Reporting			
Cause	Remedy	Supervisor	Remark Date
Remarks:			

Incident Date: June 9, 2025 Time: 01:58 hours
Final Report – Derailment Rev.1
E25766

Drafted By: SAFE 705 – 08/11/2025
Reviewed By: SAFE 703 – 08/12/2025
Approved By: SAFE 707 – 08/12/2025

Appendix F – Why-Tree Analysis

