

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

**In the Matter of the
FORT TOTTEN METRORAIL CASES
Arising Out of the Events of June 22, 2009**

**LEAD CASE: *Jenkins v. Washington
Metropolitan Area Transit Authority, et al.***

**THIS DOCUMENT RELATES TO:
ALL CASES**

Case No.: 1:10-mc-314 (RBW) (JMF)

**DEFENDANTS ALSTOM, ANSALDO AND ARINC'S
MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF THEIR JOINT
MOTION FOR SUMMARY JUDGMENT ON ALL OF THE PLAINTIFFS' CLAIMS**

TABLE OF CONTENTS

	Page(s)
STATEMENT OF FACTS	2
A. WMATA’s Automatic Train Control System And Its Composition At The Accident Site On June 22, 2009.....	2
B. In Violation Of Its Own Procedures, WMATA Failed To Either Correct Or Remove Track Circuit B2-304 From Service On June 17, 2009 While It Was Bobbing And Losing Train Detection.....	3
C. In Violation Of WMATA’s Policies and Procedures, Work Order #7169867, Which Was Opened On June 17, 2009, Was Never Acted Upon Before The June 22, 2009 Accident.....	7
D. WMATA Failed To Monitor The Loss Of Shunt Tool As Required By Its Own Procedures.....	8
E. WMATA Failed To Address The Alarms At Fort Totten In The Days And Hours Preceding The Accident.....	9
STANDARD OF REVIEW	10
ARGUMENT.....	11
I. Unforeseeable Acts of Negligence by a Third-Party Create a Superseding or Intervening Cause That Breaks the Chain of Causation.....	13
II. WMATA’s Numerous Reckless Acts Between June 17 And June 22, 2009 Were the Superseding Cause Of The Accident.....	15
A. WMATA’s June 17, 2009 Crew Placed a Known Defective Circuit Into Service.....	15
B. An Open Work Order to Fix the Malfunctioning Circuit Was Ignored by WMATA Personnel, MOC, Supervisors, and Various Crews.....	16
C. WMATA’s June 18, 2009 Crew Ignored the Dangerous Condition and Allowed a Bobbing Circuit to Remain in Service.....	17
D. WMATA Ignored Its Own Data Showing That Track Circuit B2-304 Was Failing To Detect Trains.....	17
E. WMATA Ignored Multiple Alarms and Warnings in the Five Days Before the Accident Showing that Fort Totten Track Circuits Were Failing Dangerously.....	18

III. The Undisputed Facts Establishing WMATA’s Superseding Negligence As The
Cause Of The Accident Mandate Summary Judgment For The Other Defendants.....19

CONCLUSION.....25

TABLE OF AUTHORITIES

CASES	Page(s)
<i>Anderson v. Liberty Lobby, Inc.</i> , 477 U.S. 242 (1986).....	11
* <i>Baldwin v. Harris Corp.</i> , 751 F. Supp. 2 (D.D.C. 1990).....	23, 24
<i>Braun v. New Hope Twp.</i> , 646 N.W. 2d 737 (S.D. 2002).....	20
<i>Celotex Corp. v. Catrett</i> , 477 U.S. 317 (1986).....	11
<i>Dalo v. Kitz</i> , 596 A.2d 35 (D.C. 1991)	13
<i>Dist. of Columbia v. Cassidy</i> , 465 A.2d 395 (D.C. 1983)	22
<i>Estate of Coleman v. Casper Concrete Co.</i> , 939 P.2d 233 (Wyo. 1997).....	20, 21
<i>Faris v. Potomac Elec. Power Co.</i> , 753 F. Supp. 388 (D.D.C. 1991).....	23
<i>Greene v. Dalton</i> , 164 F.3d 671 (D.C. Cir. 1999).....	11
<i>Haynes v. Williams</i> , 392 F.3d 478 (D.C. Cir. 2004).....	11
<i>Higgins v. E.I. Dupont de Nemours & Co., Inc.</i> , 671 F. Supp. 1063 (D. Md. 1987).....	23
<i>Housand v. Bra-Con Indus., Inc.</i> , 751 F. Supp. 541 (D. Md. 1990).....	23
<i>Hundley v. Dist. of Columbia</i> , 494 F.3d 1097 (D.C. Cir. 2007).....	13
<i>In re Korean Air Lines Disaster of Sept. 1, 1983</i> , No. 565, 1985 WL 9447 (D.D.C. Aug. 2,1985)	22

<i>Jackson v. Marion Cnty.</i> , 66 F.3d 151 (7th Cir. 1995)	12
<i>Kline v. ABCO Eng'g Corp.</i> , 991 F. Supp. 747 (D. Md. 1997)	23
<i>Lynch v. Norton</i> , 861 P.2d 1095 (Wyo. 1993)	20, 21, 22
<i>Majeska v. Dist. of Columbia</i> , 812 A.2d 948 (D.C. 2002)	13
<i>Mondshour v. Gen. Motors Corp.</i> , 298 F. Supp. 111 (D. Md. 1969)	14
<i>Novak v. Capital Mgmt. & Dev. Corp.</i> , 452 F.3d 902 (D.C. Cir. 2006)	13
<i>Pittway Corp. v. Collins</i> , 409 Md. 218 (Md. 2009)	23
<i>Rieser v. Dist. of Columbia</i> , 563 F.2d 462 (D.C. Cir. 1977)	14
<i>Simpson v. Washington Metro. Area Transit Auth.</i> , 688 F. Supp. 765 (D.D.C. 1988)	11
<i>Singleton v. Manitowoc Co., Inc.</i> , 727 F. Supp. 217 (D. Md. 1989)	23
<i>Sisco v. Broce Mfg., Inc.</i> , 1 F. App'x. 420 (6th Cir. 2001)	20, 21
<i>*Smith v. Hope Vill., Inc.</i> , 481 F. Supp. 2d 172 (D.D.C. 2007)	13, 14
<i>Watson v. Gold N Diamonds, Inc.</i> , 736 F. Supp. 2d 266 (D.D.C. 2010)	12
OTHER AUTHORITIES	
Fed. R. Civ. P. 56	10
Fed. R. Civ. P. 56(c)	10

Defendants Alstom Signaling Inc. (formerly d/b/a General Railway Signal (“GRS”), hereinafter “Alstom”), Ansaldo STS USA, Inc. (formerly d/b/a Union Switch & Signal, Inc., hereinafter “Ansaldo”), and ARINC Inc. (“ARINC”) hereby submit their Memorandum of Points and Authorities in Support of their joint Motion for Summary Judgment on all of the Plaintiffs’ claims against them in this action arising out of the June 22, 2009 train collision near Fort Totten Station.

As demonstrated below, the decision by co-defendant Washington Metropolitan Area Transit Authority (“WMATA”) to place a known, malfunctioning track circuit in service, and then allow it to remain in service during the five days before the June 22, 2009 accident, as a matter of law, severs any causal connection that may have existed between any alleged breach by Alstom, Ansaldo or ARINC, and the accident. WMATA has admitted that it could have prevented the accident. Its admitted negligence in failing to do so was the superseding cause of the accident.

The undisputed facts demonstrate that WMATA’s negligence was the accident’s superseding cause relieving the other defendants of liability. Specifically, WMATA failed to follow its own maintenance procedures; placed a track circuit that was not detecting trains in service; performed inadequate testing of that circuit after the bond installation; repeatedly failed to address the defective condition for five days despite numerous opportunities to do so; and failed to review its own data showing that the track circuit was not detecting trains. These plainly negligent actions establish the true superseding cause of the accident: WMATA placed and kept the faulty track circuit in service.

These undisputed facts entitle Alstom, Ansaldo, and ARINC to summary judgment as a matter of law on the Second Amended Master Complaint filed by Plaintiffs and the cross-claims filed by WMATA.

STATEMENT OF FACTS¹

While the Court is generally familiar with the facts of this case, below is a summary of the undisputed facts relevant to this Motion.

A. WMATA's Automatic Train Control System And Its Composition At The Accident Site On June 22, 2009

In the 1970s, WMATA contracted with Alstom's predecessor General Railway Signal ("GRS") to design, furnish and install the Automatic Train Control ("ATC") system for the initial portions of WMATA's Metrorail system, including the Red Line. (SOF ¶¶ 3, 14-15.) For Metrorail, WMATA uses an ATC system that consists of a series of track circuits (or "blocks"), each with an electronic transmitter, receiver, vital relay, and impedance bonds. *See id.* at ¶¶ 3, 12. The system works by the transmitter sending an audio frequency signal through a cable to the impedance bond at one end of the block. *See id.* at ¶ 12. When no train is present, the signal runs along the rails to the impedance bond at the other end of the block where it travels through a cable to the receiver, thereby completing the electrical circuit. *See id.* If the circuit is completed, the relay is energized and the block reports as unoccupied. *See id.* If a train is present, however, the train's metal wheels and axles "short" or "shunt" the signal before it reaches the impedance bond at the receiver end of the block, causing an interruption of the circuit that de-energizes the relay. *See id.* De-energizing of the relay indicates that a train occupies the particular block and

¹ For the sake of brevity, all citations herein to undisputed material facts are to those contained in the Statement of Material Facts To Which There Is No Genuine Issue filed herewith. Such citations are designated herein as "SOF ¶ __".

allows the appropriate information to be conveyed to oncoming trains in the WMATA Metrorail system. *See id.*

In 2002, WMATA began a Track Circuit Replacement Program to replace those GRS-manufactured track circuits originally installed in the Metrorail system. *See id.* at ¶ 17. In 2005, WMATA expanded the track circuit replacement program to an additional 22 locations, including Fort Totten. *See id.* at ¶ 18. Pursuant to that contract, GRS-manufactured impedance bonds and modules were to be replaced with Ansaldo-manufactured impedance bonds and modules. *See id.* at ¶ 17.

The June 22, 2009 accident occurred at the track circuit designated by WMATA as block B2-304. *See id.* at ¶¶ 6, 13, 94. At the time of the accident, the B2-304 track circuit consisted of Alstom transmitter/receiver modules and Ansaldo impedance bonds installed in 2007 and 2009. *See id.* at ¶ 13.

B. In Violation Of Its Own Procedures, WMATA Failed To Either Correct Or Remove Track Circuit B2-304 From Service On June 17, 2009 While It Was Bobbing And Losing Train Detection.

The operation and maintenance of WMATA's track circuit equipment is controlled by a number of WMATA policies and procedures including WMATA's ATC System Integrity Maintenance Practices Manual, which provides:

§ 4.3 Defects: When any component, the functioning of which is essential to the safe movement of trains, fails to perform its intended restricting safety function *or is not in correspondence (not in agreement) with known operating conditions*, train movements depending on the normal functioning of such circuit or device shall be prohibited or protected by alternate means until repairs are complete.

§ 4.3.1 Repair: The cause of the defect shall be determined and the faulty component adjusted, repaired or replaced without undue delay.

§ 4.3.2 Test: After repairs are completed and before the circuit or device is placed back into normal unrestricted service it shall be thoroughly tested to ensure that it performs its intended function and that it is in correspondence with known operating conditions.

Id. at ¶ 19 (emphasis added).

WMATA's procedures also require that after a crew installs a bond into a track circuit, the crew must verify that the track circuit is working properly through the performance of a "shunt verification test." *See id.* at ¶ 27. A track circuit must pass a valid shunt verification test before being placed into service. *See id.*

WMATA's ATC Engineers have conceded that a shunt verification test cannot be reliably performed on a "bobbing" track circuit. *See id.* at ¶ 29. A track circuit is "bobbing" when the relay fluctuates between an energized (indicating vacant) to a deenergized state (indicating occupied) regardless of whether a train is actually present in the track circuit. *See id.* at ¶ 23. According to WMATA's then-Assistant Chief Engineer, Harry Heilmann, a "[b]obbing track circuit is a malfunctioning track circuit." *See id.* at ¶ 25. Moreover, WMATA's procedures provide that corrective action for bobbing track circuits "must be taken immediately." *See id.* at ¶ 26.

On Wednesday, June 17, 2009, WMATA replaced the transmit GRS impedance bond with a US&S impedance bond at track circuit B2-304. *See id.* at ¶ 20. The WMATA Construction, Inspection and Testing ("CIT") crew performing the bond installation included crew leader Jonita Dowling and her assistant, Tyshia Jackson. *See id.* at ¶¶ 22. The CIT crew arrived at the Ft. Totten train control room at 1:45 a.m. and remained there until 5:46 a.m. *See id.* at ¶ 21. It is undisputed that the June 17 crew had difficulty adjusting track circuit B2-304 in order to get the circuit to pass a shunt verification test. *See id.* at ¶ 28.

During the adjustment of track circuit B2-304, Ms. Dowling and Ms. Jackson, who were in the Fort Totten train control room, observed the track circuit bobbing. *See id.* at ¶ 22. Moreover, the Loss of Shunt Tool Report² produced by WMATA after the accident conclusively establishes that the B2-304 track circuit was, in fact, bobbing during and after the installation of the impedance bond. *See id.* at ¶ 105. In addition, the Maintenance Operations Center (“MOC”) Operator contacted Ms. Dowling at the time of the installation to indicate that it had observed the track circuit bobbing. *See id.* at ¶ 33. The Fort Totten log book also noted that track circuit B2-304 was bobbing during the bond installation: “Noticed B2-304 trying to bob. Changed relay driver card. MOC called 0529 circuit still bobbing. Saw 304 & 312 bobbing . . . Informed MOC.” *See id.* at ¶ 33.

Mr. Heilmann and WMATA Maintenance Superintendent Matt Matyuf conceded that the bobbing track circuit prevented the installation crew from performing a valid shunt verification test on June 17, and that WMATA personnel should not have returned the bobbing track circuit to service. *See id.* at ¶¶ 29-32. Plaintiffs’ experts, Robert Halstead and Frank Rose, similarly testified that the June 17 crew should have removed track circuit B2-304 from service. *See id.* at ¶ 32.

Between 5:29 a.m. and 5:46 a.m. on June 17, 2009, Ms. Dowling and Ms. Jackson watched several trains proceed through the bobbing circuits. *See id.* at ¶ 34. During the exact time they were watching trains pass through track circuit B2-304, Loss of Shunt Tool data produced by WMATA revealed that B2-304 was, in fact, failing to detect trains. *See id.* at ¶ 105 (providing snapshot of AIM strip chart showing occupancy/vacancy of track circuit B2-304 on June 17, 2009 at time Ms. Dowling and Ms. Jackson were watching track circuit relays).

² In 2005, WMATA developed a “Loss of Shunt” (“LOS”) tool that provides “analysis and data mining of track occupancy data” to “identify potentially unsafe track circuit failures.” *See id.* at ¶ 96.

Mr. Heilmann, while examining the track circuit data at his deposition, admitted that the data showed that the track circuit was failing to detect trains during the period that Ms. Dowling and Ms. Jackson were observing the track circuit relays. *See id.* at ¶ 40. Mr. Heilmann confirmed that, based on this data, either an “absolute block”³ should have been implemented at B2-304, or the track circuit should have been removed from service immediately. *See id.* According to Johann Glansdorp and Timothy Shoppa, both WMATA corporate representatives, if WMATA personnel had reviewed the loss of shunt data for B2-304 on June 17, the circuit would have been removed from service because it showed a loss of shunt. *See id.* at ¶ 106. Even though a crew is required to remain on site until relieved and continue to troubleshoot a bobbing circuit, WMATA personnel left the Fort Totten train control room with track circuit B2-304 still bobbing. *See id.* at ¶¶ 45, 48. Ms. Dowling could have “asked [her crew] to stay and troubleshoot” the bobbing, but she did not because it was “so close to quitting time.” *See id.* at ¶ 46.

Not only did track circuit B2-304 continue to bob from June 17, 2009 until the time of the accident on June 22nd, but B2-304 also failed to detect virtually all of the trains passing through the circuit during these five days. *See id.* at ¶¶ 42, 92-93. It is undisputed that WMATA never provided Alstom, Ansaldo or ARINC with notice of bobbing circuit B2-304 from June 17, 2009 to June 22, 2009. *See id.* at ¶ 137.

Mr. Heilmann has admitted that, had an “absolute block” been placed on B2-304, or had B2-304 been taken out of service pursuant to WMATA policy and procedure, the June 22, 2009 accident would never have occurred. *See id.* at ¶¶ 32, 40. Several other WMATA witnesses, and

³ An “absolute block” shuts down a portion of the railroad to evaluate potential problems. *See id.* at ¶ 58.

Plaintiffs' experts, have similarly admitted that track circuit B2-304 should have been removed from service prior to June 22, 2009. *See id.* at ¶¶ 44, 63.

C. In Violation Of WMATA's Policies and Procedures, Work Order #7169867, Which Was Opened On June 17, 2009, Was Never Acted Upon Before The June 22, 2009 Accident.

After the June 17 crew left Fort Totten, WMATA's MOC opened Work Order #7169867 at 6:50 a.m. for the bobbing track circuit B2-304. *See id.* at ¶ 53. According to WMATA's Maintenance Superintendent, Mr. Matyuf, "the intent is to respond to the work order, carry out the task it involves, and correct[] the deficiency noted in the work order" and close out the work order "within one business day of satisfactory completion of the work." *See id.* at ¶ 55. WMATA MOC was required to follow up on Work Order #7169867 and ensure that it was closed, but neither the employee who had opened the work order nor anyone else at MOC followed up prior to the accident. *See id.* at ¶¶ 86-89.

Coincidentally, a separate WMATA maintenance crew visited the Fort Totten train control room on June 18, 2009 to perform routine maintenance. *See id.* at ¶ 64. Even though the WMATA computer system (the "Maximo system") contained the pending Work Order #7169867, and the leaders of the June 18 crew checked Maximo prior to entering the Ft. Totten train control room, they did not see the pending Work Order because they were not trained on how to access such work orders. *See id.* at ¶ 65. Additionally, members of the June 18 crew spoke with the MOC prior to beginning their preventative maintenance procedure, but MOC never informed the crew of pending Work Order #7169867. *See id.* at ¶ 66.

During their nearly four-hour visit to the Fort Totten train control room, the June 18 crew observed that track circuit B2-304 was bobbing and losing speed commands, which indicates that the track circuit could be failing. *See id.* at ¶¶ 69-70, 73-75. Nonetheless, the crew did not open a new work order for the bobbing track circuit or report the issue to MOC. *See id.* at ¶¶ 72, 77.

Instead, the crew left the Fort Totten train control room with B2-304 still bobbing. *See id.* at ¶ 79.

The next day, Friday, June 19, 2009, a separate group of WMATA personnel entered the Fort Totten train control room for inspections. *See id.* at ¶ 80. The June 19 crew also failed to open Work Order #7169867 and B2-304 continued to bob. *See id.* at ¶¶ 81, 92. On the day of the accident, WMATA personnel again entered the Fort Totten train control room at or about 9:30 a.m. *See id.* at ¶ 82. Like the June 18 and June 19 crews, the June 22 crew also failed to open or act upon pending Work Order #7169867, and consequently B2-304 was yet again left bobbing. *See id.* at ¶¶ 84-85, 92. At the time of the accident on June 22, 2009, Work Order #7169867 remained open and ignored in violation of WMATA procedure. *See id.* at ¶¶ 90-91. Track circuit B2-304, which had still never been properly verified, was still bobbing at the time of the collision. *See id.* at ¶¶ 29-31, 92.

D. WMATA Failed To Monitor The Loss Of Shunt Tool As Required By Its Own Procedures.

In 2005, WMATA developed a “loss of shunt” (“LOS”) tool that provides “analysis and data mining of track occupancy data” to “identify potentially unsafe track circuit failures.” *See id.* at ¶ 96. Initially, the tool was to be monitored on a weekly basis by the ATC Engineering department. *See id.* at ¶ 99. In July 2006, the WMATA Engineering department transferred responsibility for monitoring the LOS tool to the WMATA Maintenance department, led by Karl Spencer, which was expected to run the tool monthly. *See id.* at ¶¶ 100-101. Mr. Spencer, however, testified that it was never his responsibility or the responsibility of the Maintenance department to run the LOS tool. *See id.* at ¶ 103. Mr. Matyuf, the WMATA Maintenance Superintendent in 2009, similarly testified that “[t]he maintenance department never took on the responsibility of monitoring” the LOS tool. *See id.* at ¶ 104.

As noted above, LOS Tool data produced by WMATA after the accident showed a loss of train detection on track circuit B2-304 for virtually all of the trains passing through the circuit between June 17, 2009 and the time of the accident. *See id.* at ¶¶ 93, 105, 107. Like Mr. Heilmann, Mr. Glansdorp and Mr. Shoppa, both WMATA corporate representatives, testified that if WMATA had been reviewing the loss of shunt data between June 17 and June 22, 2009, track circuit B2-304 would have been shut down. *See id.* at ¶ 106. In August 2009, Mr. Shoppa wrote that if the loss of shunt data had been reviewed anytime from June 17 to June 22, 2009, *the accident would have been prevented.* *See id.* at ¶ 110.

E. WMATA Failed To Address The Alarms At Fort Totten In The Days And Hours Preceding The Accident.

The Advanced Information Management (“AIM”) system generates an icon on the track display when its logic detects a non-reporting block, also known as an “NRB”. *See id.* at ¶ 115. WMATA’s expert, James Bilodeau, testified that an NRB represents a dangerous condition that should be immediately repaired. *See id.* at ¶ 117. The AIM system also generates an alarm message (“track circuit failed vacant”) for this condition. *See id.* at ¶ 115. A “track circuit failed vacant” alarm means that the track circuit is reporting a vacancy when, in fact, the track circuit may actually be occupied.⁴ *See id.* at ¶ 116.

Between June 17 and June 22, the AIM system generated “hundreds and hundreds” of “track circuit failed vacant” alarms on the Red Line, including in the area of the accident between Takoma and Fort Totten. *See id.* at ¶ 128. In the hour before the June 22nd accident, the AIM system generated seventeen separate “track circuit failed vacant” alarms on the Red Line, including six in the area of the accident between Takoma and Fort Totten. *See id.* at ¶ 129. Two minutes before the accident, while Train 214 was stopped between Takoma and Fort Totten, the

⁴ Plaintiffs’ experts, Robert Halstead, Stephen Timko and Frank Rose agree that an NRB or failed vacant alarm implicates “one of the most serious conditions.” *See id.* at ¶ 117.

AIM system generated a “track circuit failed vacant” icon and alarm for that area of the track circuit. *See id.* at ¶ 131. Mr. Floyd, one of the two Metro Operations Control Center (“OCC”) controllers with responsibility for the Red Line during this time, saw the track circuit failed vacant alarm and the corresponding icon demonstrating the existence of a non-reporting block in the area of the accident two minutes before the collision occurred. *See id.* at ¶ 133. There is no evidence, however, that Mr. Floyd acted upon this information or took any steps to notify the proper personnel. *See id.* at ¶¶ 134-35.

Prior to the June 22nd accident, if there was a track circuit failure, OCC controllers had the authority to institute an absolute block between specific locations of track into which no train would be allowed to enter. *See id.* at ¶¶ 58, 122. However, there was no procedure in the OCC for responding to the track circuit failed vacant alarm. *See id.* at ¶ 125. Neither controller on duty at the time of the accident instituted an absolute block at B2-304. *See id.* at ¶¶ 123, 135. Both testified that it was not their practice to institute a block in response to a failed vacant alarm. *See id.* at ¶¶ 123, 126, 134. Plaintiffs’ expert, Stephen Timko, and WMATA’s expert, James Bilodeau, opined that had WMATA instituted an absolute block at B2-304, the accident would have been prevented. *See id.* at ¶¶ 61-62.

On June 22, 2009 at approximately 4:58 p.m., WMATA train 112 collided with the rear end of stopped train 214 at the B2-304 track circuit. *See id.* at ¶ 6.

STANDARD OF REVIEW

Under Rule 56 of the Federal Rules of Civil Procedure, summary judgment must be granted when “the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” Fed. R. Civ. P. 56(c);

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247 (1986). To determine which facts are “material,” a court must look to the substantive law on which each claim rests. *Anderson*, 477 U.S. at 248. A “genuine issue” is one whose resolution could establish an element of a claim or defense and, therefore, affect the outcome of the action. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986).

Once the moving party carries its initial burden, the nonmoving party must “go beyond the pleadings” and designate “specific facts showing that there is a genuine issue for trial.” *Id.* at 324 (internal quotations and citation omitted). This means that the non-movant may not rely solely on allegations or conclusory statements. *Greene v. Dalton*, 164 F.3d 671, 675 (D.C. Cir. 1999). Instead, the non-moving party must present facts that would enable a reasonable jury to find in its favor. *See id.* If the evidence presented by the non-moving party is “merely colorable, or is not significantly probative,” summary judgment must be granted. *Haynes v. Williams*, 392 F.3d 478, 485 (D.C. Cir. 2004) (internal citations and quotations omitted). Finally, a party’s own deposition testimony is enough to establish that no genuine issue of fact exists. *Simpson v. Washington Metro. Area Transit Auth.*, 688 F. Supp. 765, 768 (D.D.C. 1988) (granting summary judgment for defendant after holding “that by plaintiff’s own deposition testimony under oath there is not a question of fact as to which reasonable minds could differ” on material issue).

ARGUMENT

The material facts are undisputed, overwhelming, and, by WMATA’s own admission, “perfectly clear” that WMATA “could have stopped the accident” between June 17 and June 22, 2009. *See id.* at ¶ 113. The key undisputed fact is that WMATA placed a known, malfunctioning track circuit in service, contrary to its own policies. Its subsequent gross

inattention to addressing this dangerous condition unreasonably compromised a vital track circuit.

This condition was not related to a minor maintenance issue or a non-safety related component, but rather to the most important piece of train detection safety equipment in WMATA's entire system, and on a line serving thousands of passengers each day. WMATA knew that if the train detection system failed to detect a train occupying the track circuit, then it would create a seriously dangerous condition on its rail system. Even in their own complaint, Plaintiffs allege that WMATA "kn[ew] of the exact train detection problem that led to the crash five days in advance."⁵ Yet WMATA did nothing.

Even if the Court found Alstom, Ansaldo, or ARINC's equipment to be defective, or that there was a lack of safety testing, WMATA's reckless actions were the superseding cause of the accident, thereby relieving Alstom, Ansaldo, and ARINC of all liability as a matter of law.

⁵ Plaintiffs' Second Amended Complaint alleges:

[T]he train detection system on the portion of track where Train 214 was stopped was malfunctioning and not detecting trains. This condition at this portion of track had been known to WMATA since at least June 17, 2009, was the subject of a pending work order, but was never addressed before the collision. (SAMC ¶ 163).

[T]he crash occurred despite WMATA knowing of the exact train detection problem that led to the crash five days in advance. (SAMC ¶ 171).

Plaintiffs may not argue contrary to the factual allegations of their complaint, as those allegations are judicial admissions conclusively binding on Plaintiffs. *See Watson v. Gold N Diamonds, Inc.*, 736 F. Supp. 2d 266, 270 (D.D.C. 2010) ("Under well-settled case law, a party is generally bound by the facts he alleges in his pleadings."); *Jackson v. Marion Cnty.*, 66 F.3d 151, 153-54 (7th Cir. 1995) ("Allegations in a complaint are binding admissions, . . . and admissions can of course admit the admitter to the exit from the federal courthouse.").

I. UNFORESEEABLE ACTS OF NEGLIGENCE BY A THIRD PARTY CREATE A SUPERSEDING OR INTERVENING CAUSE THAT BREAKS THE CHAIN OF CAUSATION.

Central to the determination of a negligence action is whether the allegedly negligent acts of the defendant proximately caused the injuries.⁶ *See Smith v. Hope Vill., Inc.*, 481 F. Supp. 2d 172, 184 (D.D.C. 2007) (Walton, J.) (citations omitted). Proximate causation, which may be demonstrated by “either direct or circumstantial evidence,” is defined “as that cause which, in natural and continual sequence, *unbroken by any efficient intervening cause*, produces the injury, and without which the result would not have occurred.” *Id.* at 199-200 (emphasis added) (quoting *Dist. of Columbia v. Zukerberg*, 880 A.2d 276, 281 (D.C. 2005)); *see also Majeska v. Dist. of Columbia*, 812 A.2d 948, 950 (D.C. 2002).

However, when a superseding or intervening cause occurs, the proximate chain of causation is broken. “[A]n intervening force breaks the chain of proximate causation when that intervening force is sufficiently unforeseeable as to constitute a superseding cause.” *Hundley v. Dist. of Columbia*, 494 F.3d 1097, 1104 (D.C. Cir. 2007) (citation omitted); *Dalo v. Kitz*, 596 A.2d 35, 42 (D.C. 1991) (An intervening or superseding act that “breaks the chain of causation” will relieve a party of any liability for its wrongdoing).

“A superseding cause is an act of a third person or other force which by its intervention prevents the actor from being liable for harm to another which [its] antecedent negligence is a substantial factor in bringing about.” *Hope Vill., Inc.*, 481 F. Supp. 2d at 202-03 (citation omitted). In order to terminate liability, the superseding cause must be unforeseeable to the original tortfeasor. *See id.* at 200 (“An intervening negligent or criminal act breaks the chain of

⁶ To establish negligence in the District of Columbia, a plaintiff must prove a duty of care owed by the defendant to the plaintiff, a breach of that duty by the defendant, and damage to the interests of the plaintiff that were proximately caused by the breach. *Novak v. Capital Mgmt. & Dev. Corp.*, 452 F.3d 902, 907 (D.C. Cir. 2006) (citation omitted).

causation if it is not reasonably foreseeable.”) (citation omitted). Therefore, “[w]here two tortfeasors are involved, the unforeseeable action of a subsequent tortfeasor may be a superseding cause which breaks the chain of causation. *Id.* at 202 (citation omitted).

Notably, another party’s *failure to take action to prevent a dangerous situation* can constitute a superseding cause. *Rieser v. Dist. of Columbia*, 563 F.2d 462, 480 n.93 (D.C. Cir. 1977) (citing Restatement (Second) of Torts § 452 (1965)). *See also Mondshour v. Gen. Motors Corp.*, 298 F. Supp. 111, 114 (D. Md. 1969) (granting bus manufacturer’s motion to dismiss, in part, due to subsequent superseding conduct of bus owner who neglected to inspect and properly maintain its equipment). Moreover, “liability may shift where ‘a third person becomes aware of the danger, and is in a position to deal with it.’” *Rieser*, 563 F.2d at 480 (quoting W. Prosser, *Handbook of the Law of Torts* at 283 (4th ed. 1971)).

Under well-established principles of negligence law in the District of Columbia, and indeed throughout the United States, undisputed material facts establishing a superseding cause require the dismissal of claims against alleged tortfeasors earlier in the chain of causation as a matter of law. Here, Plaintiffs cannot make out a claim against Alstom, Ansaldo and ARINC because the record is replete with WMATA’s own admissions that it violated its procedures by placing a known, malfunctioning track circuit into service and leaving it in service from June 17, 2009 to June 22, 2009. Alstom, Ansaldo and ARINC could not have foreseen WMATA’s disregard of its many safety protocols. There are no facts in dispute on this issue. Simply put, had WMATA adhered to its own safety policies and procedures, no accident would have occurred.

II. WMATA’S NUMEROUS RECKLESS ACTS BETWEEN JUNE 17 AND JUNE 22, 2009 WERE THE SUPERSEDING CAUSE OF THE ACCIDENT.

WMATA’s decision to place a malfunctioning track circuit in service followed by its multiple failures to attend to the obviously malfunctioning circuit in violation of its basic policies and procedures during the five days before the accident were unforeseeable actions that broke the causal chain. While the relevant facts are detailed above in the Statement of Facts section, the following key undisputed facts summarize WMATA’s actions and inactions that were the sole superseding cause of the accident.

A. WMATA’s June 17, 2009 Crew Placed a Known Defective Circuit Into Service.

On June 17, 2009, the WMATA CIT crew at Fort Totten witnessed track circuit B2-304 bobbing during and after the bond installation. (SOF ¶¶ 22, 33-35, 105.) WMATA personnel testified that a bobbing track circuit “is a malfunctioning track circuit” that can lead to a potentially “critical safety problem.” *See id.* at ¶¶ 24-26. When WMATA’s June 17 crew saw track circuit B2-304 bobbing, WMATA’s own procedures mandated that they not place it back into service. *See id.* at ¶¶ 19, 26-27. WMATA then-Assistant Chief Engineer, Mr. Heilmann, testified that the June 17 crew “should not have returned [B2-304] to service” and “[n]o accident would have happened five days later if the track circuit was out of service until the bobbing was corrected.” *See id.* at ¶¶ 32, 49 (emphasis added).

After a bond is replaced, WMATA’s procedures also require WMATA personnel to verify the track circuit through a shunt verification test before the circuit is placed in service.⁷ *See id.* at ¶ 27. Mr. Heilmann confirmed that a valid shunt verification test cannot be performed while a track circuit is bobbing. *See id.* at ¶ 29. Mr. Heilmann also admitted that track circuit

⁷ WMATA’s ATC System Integrity Maintenance Practices Manual §10.4 provides: “track circuits must be verified immediately after any adjustment, repair, or replacement of their vital components including . . . bonds.” *Id.* at ¶ 27.

B2-304 was bobbing during the shunt verification test on June 17, 2009. *See id.* at ¶ 30. Because B2-304 was bobbing during the shunt verification test on June 17th, the CIT crew violated WMATA's procedures by placing a track circuit in service that had not been properly verified. *Id.* at ¶¶ 19, 27, 30-32. Mr. Heilmann conceded that he "d[id] not believe that [the June 17 crew] had a successful test." *See id.* at ¶ 31.

In direct violation of its own procedures and of plain common sense in dealing with such sensitive safety-related equipment, WMATA put the faulty circuit back into service and its CIT crew left the area because it was "quitting time." *See id.* at ¶¶ 46, 48.

B. An Open Work Order to Fix the Malfunctioning Circuit Was Ignored by WMATA Personnel, MOC, Supervisors, and Various Crews.

On June 17, WMATA's MOC opened a work order to repair the bobbing circuit at Fort Totten. *See id.* at ¶ 53. WMATA's MOC was supposed to follow up with crews to make sure that the work order to fix the circuit was being acted upon, "within one business day"; instead it failed to take any action whatsoever over the course of five days. *See id.* at ¶¶ 55, 86-89. As a result, at the time of the accident, the work order had not been acted upon by any WMATA personnel, and the dangerously malfunctioning circuit remained in service. *See id.* at ¶¶ 90, 92-93.

WMATA's Superintendent of Maintenance, Mr. Matyuf, testified that it was a violation of WMATA procedure for a work order to be open, and not acted upon, for five days. *See id.* at ¶ 91. Regardless of WMATA's obvious violation of its own procedures, ignoring for five days a work order to fix a dangerous, malfunctioning circuit that is in service on a busy set of tracks used by thousands of passengers each day is unacceptable, unforeseeable and plainly negligent by any standard.

C. WMATA’s June 18, 2009 Crew Ignored the Dangerous Condition and Allowed a Bobbing Circuit to Remain in Service.

On June 18, 2009, a different WMATA crew went to the Fort Totten train control room to perform a required quarterly track circuit adjustment test unrelated to the difficulties experienced by the June 17 crew. *See id.* at ¶ 64. The June 18 crew contacted MOC, but MOC failed to inform the crew about the pending work order for B2-304. *See id.* at ¶¶ 66-67. Like the June 17 crew, the June 18 crew saw track circuit B2-304 bobbing when they were in the Fort Totten train control room. *See id.* at ¶ 70. And just like the June 17 crew, the June 18 crew failed to correct the bobbing track circuit or remove it from service. *See id.* at ¶¶ 71-72. Although WMATA’s procedures required that a defective circuit not be placed or kept in service, the June 18 crew left the train control room with B2-304 still in service. *See id.* at ¶¶ 19, 26-27, 43, 71. WMATA crews also visited the Fort Totten train control room on June 19 and the morning of June 22, but did not access or attend to the open work order to fix the circuit. *See id.* at ¶¶ 80-82, 84-85.

D. WMATA Ignored Its Own Data Showing That Track Circuit B2-304 Was Failing To Detect Trains.

From June 17, 2009 until the time of the accident (June 22, 2009 at approximately 4:58 pm), track circuit B2-304 bobbed. *See id.* at ¶ 92. During this same time period, track circuit B2-304 failed to detect nearly every train that passed through the circuit. *See id.* at ¶ 93.

Since 2005, WMATA’s “loss of shunt” (“LOS”) tool provided “analysis and data mining of track occupancy data” to “identify potentially unsafe track circuit failures.” *See id.* at ¶ 96. WMATA understood the danger this posed as early as 2005, namely that loss of shunt could lead to a potentially catastrophic rear-end collision. *See id.* at ¶ 98. The loss of shunt tool uses data from the field to determine whether there is a “gap in [train] detection” somewhere in the system.

See id. at ¶ 97. An undetected train is the most dangerous track circuit condition. *See id.* at ¶¶ 35-36, 43.

The loss of shunt tool showed a loss of train detection on track circuit B2-304 for virtually all of the trains passing through the circuit between June 17 and the accident. *See id.* at ¶ 107. Even the most cursory review of the daily loss of shunt data between June 17 and June 22, 2009, would have revealed that there was a loss of detection for almost every train progressing through B2-304 during this period. *See id.* at ¶¶ 42, 107-09. WMATA has unequivocally admitted that it failed to review its own track circuit data during the critical time that it placed the malfunctioning circuit in service, which was the superseding cause of the accident. As WMATA's corporate representative wrote in two separate email messages after the accident, the accident could have been prevented if WMATA was running the loss of shunt tool:

[i]f [the loss of shunt] report had been run and analyzed between the June 17 unsafe failure and the June 22 collision, *we could have prevented the collision.*

* * *

I think it's perfectly clear that *we could have stopped the accident* if we had run the loss-of-shunt tool between June 17 and June 22, but we didn't.

See id. at ¶¶ 110-111, 113. (emphasis added).

E. WMATA Ignored Multiple Alarms and Warnings in the Five Days Before the Accident Showing that Fort Totten Track Circuits Were Failing Dangerously.

Among its many other negligent acts, WMATA also ignored its own multiple alarms and warnings that could have prevented the accident. In the WMATA OCC, graphic, text and audible alarms sound if a track is reporting vacant when its computer determines that the track may in fact be occupied. *See id.* at ¶¶ 114-15, 127. OCC employees with specific responsibility

for the Red Line, along with supervisors for the entire railroad, were watching the computer system continuously in the days leading to the accident. *See id.* at ¶ 118.

There is no evidence that, in the five days before the accident, WMATA's OCC personnel ever noted, or took any action on, the hundreds of "track circuit failed vacant" alarms that identified the malfunctioning circuit at Fort Totten. *See id.* at ¶¶ 128, 135. In the hour before the accident, seventeen separate "track circuit failed vacant" alarms rang on the Red Line. *See id.* at ¶ 129. In the minutes before the accident, there were three alarms that alerted OCC personnel of a "non-reporting block"/"track circuit failed vacant" in the vicinity of the Fort Totten station, yet no one at WMATA responded despite WMATA's testimony that these alarms were seen. *See id.* at ¶¶ 130-31. No one in the OCC or the MOC acted on the failed vacant alarms because OCC and MOC personnel did not grasp the urgency of the dangerous situation. *See id.* at ¶¶ 120-21, 124-26.

As WMATA's corporate representative concluded after the accident, WMATA OCC personnel did not act on any of these alarms from Fort Totten in the five days before the accident even though "those are the ones [they] could've acted on to remedy the unsafe condition and prevent the accident." *See id.* at ¶ 135. Despite these multiple warnings that could have prevented the accident, WMATA, yet again, did nothing.

III. THE UNDISPUTED FACTS ESTABLISHING WMATA'S SUPERSEDING NEGLIGENCE AS THE CAUSE OF THE ACCIDENT MANDATE SUMMARY JUDGMENT FOR THE OTHER DEFENDANTS.

Alstom, Ansaldo, and ARINC cannot be held liable in the face of these undisputed facts. These defendants could not have foreseen WMATA's numerous and reckless decisions, including: (1) placing a malfunctioning track circuit into service; (2) disregarding its own safety testing protocols; and (3) ignoring repeated, blatant red flags that the circuit was not detecting trains. WMATA's disregard of its most basic safety protocols repeatedly over the five days after

it placed, and then allowed, a malfunctioning track circuit to remain in service was impossible to anticipate.

Significantly, courts have granted summary judgment when presented with factual scenarios analogous to WMATA's failure to correct a known danger. Specifically, courts will grant summary judgment when a third party discovers a dangerous situation, has the ability to remedy the situation, but fails to take any action. *See, e.g., Braun v. New Hope Twp.*, 646 N.W. 2d 737, 742 (S.D. 2002) ("If a third person 'fully discovers the danger and then proceeds, in deliberate disregard of it . . . to inflict upon the plaintiff the danger which the third person has discovered' then the responsibility is shifted to the third party." (citation omitted)).

Three cases in particular, *Sisco v. Broce Mfg., Inc.*, 1 F. App'x. 420 (6th Cir. 2001), *Estate of Coleman v. Casper Concrete Co.*, 939 P.2d 233 (Wyo. 1997), and *Lynch v. Norton*, 861 P.2d 1095 (Wyo. 1993), present strikingly similar facts to this case. In all three, the court granted summary judgment because a third-party equipment or property owner negligently disregarded a known hazard.

In *Sisco*, a self-propelled highway sweeper machine, known as a "broom," killed an employee. 1 F. App'x. at 421. The widow of the decedent sued the broom manufacturer, alleging the defective design and manufacture of the broom was a cause of the accident. *Id.* at 421. The *Sisco* court, however, held that the post-sale actions of the decedent's employer were a superseding cause of the accident, severing the manufacturer's liability. *Id.* at 424. It pointed to the employer's "failure to repair the [broom's] brakes despite repeated, actual knowledge of problems with them." *Id.* at 423. These failures included: (1) a warning of the broom's malfunctioning by the foreman three weeks before the accident; (2) an incident a week before the accident in which the broom's brakes gave out while another employee was operating the broom;

and (3) a complaint by another employee regarding the broom's "floppy" brake handle the day before the accident. *Id.*

The *Sisco* court noted that the employer never notified the manufacturer regarding the brake issue. *Id.* at 425. In affirming the lower court's grant of summary judgment to the manufacturer, the court explained that because the manufacturer "could not reasonably have foreseen that [the employer] would fail to repair the broom's brakes," "the chain of causation was broken." *Id.* at 423.

Similarly, in *Estate of Coleman*, the plaintiff was injured in an automobile accident after a traffic signal malfunctioned. 939 P.2d at 235. The State had discovered the malfunctioning traffic signal two days before the accident but failed to repair it or notify the contractor of the malfunction. *Id.* at 237. In granting summary judgment, the court held that the State's failure to act constituted a superseding cause cutting off the contractor's liability. *See id.* ("Assuming, arguendo, that admissible evidence had been produced indicating that the negligence of the appellees engendered the signal malfunction, the State's failure to repair the dangerous condition or request the same of the appellees constituted an effective intervening cause."). *Estate of Coleman* underscores the point that regardless of any antecedent negligence on the part of the other defendants, WMATA's negligence terminates any and all previous liability.

In *Lynch*, the plaintiff was injured when she slipped on an icy school sidewalk and sued the contractor who had installed the sidewalk. *See Lynch*, 861 P.2d at 1096. The court ruled, as a matter of law, that a school district's failure to repair an obviously dangerous condition after receiving complaints constituted a superseding cause that relieved the contractor of all liability. *Id.* at 1099-1100. The court explained that the school district's failure to correct a known defect was not reasonably foreseeable, and therefore broke the chain of causation which originated from

the contractor's alleged defective and negligent work. *See id.* at 1100 ("Norton could not reasonably have foreseen that the school district, when confronted with a dangerously icy sidewalk, due to a drainage problem, would not inform Norton of the obvious defect [and] would not repair the defect itself. . .").

WMATA's actions from June 17 to June 22, 2009 mirror the negligent conduct displayed by the parties mentioned above: (1) WMATA became aware of a dangerous situation that it had the ability to correct; (2) it had numerous opportunities to correct the situation; (3) it ignored the danger for an unreasonable amount of time; and (4) the accident occurred. When presented with almost the exact same factual pattern, courts have recognized that, **as a matter of law**, such negligent conduct was a superseding cause cutting off all other liability. Here, instead of addressing the known danger, WMATA sat idle while alarm bells literally rang.

These undisputed facts demonstrate that this case falls squarely within the legal principles that a defendant will not be held liable when the unexpected actions of a superseding tortfeasor interrupt the chain of causation. Between June 17 and 22, WMATA put in service a circuit that was not detecting trains; squandered multiple opportunities to prevent the accident; did not perform actions mandated by its own procedures or policies in attending to an obvious and known malfunctioning track circuit; ignored numerous alarms; and did not review its own tools showing that the circuit was not detecting trains.

While "proximate causation, including the question of superseding cause, [] is ordinarily a question of fact for the jury, [when] the issues presented are so clear [] the Court may decide them as a matter of law." *In re Korean Air Lines Disaster of Sept. 1, 1983*, No. 565, 1985 WL 9447, *8 (D.D.C. Aug. 2, 1985) (internal citation and quotations). *See also Dist. of Columbia v. Cassidy*, 465 A.2d 395, 397 (D.C. 1983) ("While normally the jury is the trier of fact, a trial

court may ‘remove from jury consideration those cases in which the facts, viewed most favorably to the nonmoving party, permit but one reasonable conclusion as to the proper judgment.’” (internal citations omitted); *Pittway Corp. v. Collins*, 409 Md. 218, 253 (Md. 2009) (proximate cause may be decided as an issue of law where “reasoning minds cannot differ”) (citation omitted).

Several courts applying D.C. law have granted summary judgment based on a third party’s superseding negligence. *See Baldwin v. Harris Corp.*, 751 F. Supp. 2, 5 (D.D.C. 1990) (granting summary judgment in favor of equipment manufacturer because equipment owner’s negligence constituted a superseding cause); *see also Faris v. Potomac Elec. Power Co.*, 753 F. Supp. 388 (D.D.C. 1991) (granting summary judgment in favor of defendant due to intervening negligence). In *Baldwin*, this Court granted summary judgment to a machine manufacturer, finding that the machine owner’s negligent maintenance of the equipment was a superseding cause that relieved the manufacturer of liability. 751 F. Supp. at 5. In granting summary judgment, the *Baldwin* Court explained that “since the injury would not have occurred had the product been used as designed, and the employer’s negligence was not reasonably foreseeable by the manufacturer, plaintiff’s claims of negligent and defective product design must fail.” *Id.* at 5.⁸

⁸ Other jurisdictions have similarly granted summary judgment in favor of a defendant when a third party’s negligence constitutes a superseding cause cutting off any liability to the defendant. *See, e.g., Kline v. ABCO Eng’g Corp.*, 991 F. Supp. 747, 750 (D. Md. 1997) (granting summary judgment for equipment manufacturer when equipment owner instructs employee to use the equipment in a dangerous way); *Housand v. Bra-Con Indus., Inc.*, 751 F. Supp. 541,546 (D. Md. 1990) (granting manufacturer’s summary judgment motion based on equipment owner’s superseding negligence); *Singleton v. Manitowoc Co., Inc.*, 727 F. Supp. 217, 226 (D. Md. 1989) (granting manufacturer’s motion for summary judgment because equipment owner’s negligence, including failure to maintain, inspect and conform equipment to current safety standards, constituted superseding cause); *Higgins v. E.I. Dupont de Nemours & Co., Inc.*, 671 F. Supp. 1063, 1066 (D. Md. 1987) (granting manufacturer’s motion for summary judgment due to unforeseeable superseding negligence of third party).

WMATA's negligence was simply not reasonably foreseeable in this case. At no time between June 17 and June 22 did WMATA inform Alstom, Ansaldo or ARINC that it had put a malfunctioning track circuit back in service, that it was experiencing ongoing bobbing issues at Fort Totten, that alarms were being generated in that area, or that the loss of shunt tool showed a loss of train detection on those circuits. Just as the manufacturer in *Baldwin* could not reasonably have foreseen that the employer would negligently use and maintain its equipment, the other defendants could not reasonably have foreseen that WMATA would knowingly allow a malfunctioning track circuit to remain in service in violation of its own procedures; fail to act on a work order for five days in violation of its own procedures; fail to monitor tools developed specifically to warn of defective circuits; and ignore alarms showing defective circuits. WMATA's obvious negligence in each of these areas is enough to break the chain of causation regardless of any antecedent negligence on the part of Alstom, Ansaldo or ARINC. Together, they show that Alstom, Ansaldo and ARINC have no liability here as a matter of law.

CONCLUSION

Based on the undisputed material facts, Alstom, Ansaldo and ARINC respectfully request that the Court enter summary judgment on their behalf on all of the Plaintiffs' claims and all WMATA cross-claims against them.

November 11, 2011

Respectfully submitted,

/s/ Robert P. Fletcher

Robert F. Reklaitis, Esq. (# 358973)
Leslie Paul Machado, Esq. (# 472395)
Robert P. Fletcher, Esq. (#375543)
LECLAIR RYAN
1101 Connecticut Avenue, N.W.
Suite 600
Washington, DC 20036

***Attorneys for Defendant Ansaldo STS
USA, Inc.***

/s/ Timothy M. Broas

Timothy M. Broas, Esq. (# 391145)
John J. Rosenthal, Esq. (# 425263)
WINSTON & STRAWN, LLP
1700 K Street, N.W.
Washington, DC 20006-3817

***Attorneys for Defendant Alstom Signaling
Inc.***

/s/ Richard M. Barnes

Richard M. Barnes, Esq. (# MD00669)
Linda S. Woolf, Esq. (# MD084724)
K. Nichole Nesbitt, Esq. (# 469793)
Craig S. Brodsky, Esq. (# 454924)
GOODELL DEVRIES LEECH & DANN,
LLP
One South Street
20th Floor
Baltimore, MD 21202

Attorneys for Defendant ARINC, Inc.