

[FE-36-98](#) (document link)

SUMMARY FOR FE-36-98:
SELECTED AND POSSIBLE CONTRIBUTING FACTORS

SELECTED FACTORS

Railroad: Union Pacific Railroad Company

Location: Gothenburg, Nebraska

Region: Region 6

Month: December

Date: 12/22/98

Time: 9:20 p.m., CST

Data for Fatally Injured Employee(s)

Assistant Track Foreman

44 years old

24 years of service

Last rules training: January 1998

Last safety training: January 1998

Last physical: December 1997

Data for All Employees (Craft, Positions, Activity)

Craft: MOW

Positions:

Track Gang

Track Foreman

Assistant Track Foreman

Tamper Operator

Tamper Operator's Helper

Ballast Regulator Operator

Contracted Crew Van Driver

Work Train

Locomotive Engineer

Conductor

Brakeman

Activity: Track repair following a 27-car derailment the day before.

SUMMARY FOR FE-36-98 CONTINUED

POSSIBLE CONTRIBUTING FACTORS

EVENT

An Assistant Track Foreman was fatally injured when struck by a tamper coming toward him.

PCF No. 1

The Assistant Track Foreman was on his way along a maintenance service road to shut the doors on the ballast train. Abruptly and without looking both ways and otherwise exercising due diligence on the tracks, he turned and stepped up onto Track No. 1 in front of a tamper coming toward him at 5 mph.

PCF No. 2

The area where the ballast was unloaded had temporary lighting, provided by portable power plants, while the area west of there, including the accident site, was dark. Nevertheless, the Assistant Track Foreman declined the offer of the Conductor's lantern and removed his reflective striped vest, leaving it in the center of Track No. 1. The only light was provided by the Crew Van Driver who followed 100 feet behind him to assist with his headlights.

REPORT: FE-36-98

RAILROAD: Union Pacific Railroad Company (UP)

LOCATION: Gothenburg, Nebraska

DATE & TIME: Dec. 22, 1998, 9:20 p.m., CST

PROBABLE CAUSE: The Assistant Track Foreman was fatally injured when struck by a tamper as he stepped onto the track without ensuring it was clear.

EMPLOYEE:

Occupation:	Assistant Track Foreman
Age:	44 Years
Length of Service:	24 Years
Last Rules Training:	Jan. 13, 1998
Last Safety Training:	Jan. 12, 1998
Last Physical:	Dec. 23, 1997

CIRCUMSTANCES PRIOR TO THE ACCIDENT

At approximately 9:30 a.m. on the day of the accident, an Assistant Foreman reported for duty at Willow Island, Nebraska to assist in repairing the track at milepost 245.1 after a 27-car derailment had destroyed parts of three main lines on Dec. 21, 1998. Milepost 245.1 was located approximately three miles east of Gothenburg, Nebraska.

The Assistant Foreman was with a work group unloading ballast at the derailment site on Track No. 2 from a 45-car work train. After unloading three cars of ballast from the middle of the ballast train, the train pulled approximately one-quarter mile west. The movement was necessary to clear the area where the ballast had been dumped to allow surfacing to begin. After a short job briefing, the Assistant Foreman began walking west on the north side of the ballast train between Tracks Nos. 1 and 2.

At about the same time, a work train, tamper, and ballast regulator were preparing to move west on Track No. 1. The work crews had just completed surfacing on Track No. 1 and were heading to the crossover switches at CPB 254. The work train, tamper, and ballast regulator were lined up east to west, respectively.

Also at this time, a Crew Van Driver contracted by the railroad had just picked up the Conductor and Brakeman who had been working on the same ballast train with the Assistant Foreman. They were on the maintenance road that ran parallel to the main lines and lay to the north of all three tracks. The van was heading west to pick up the Locomotive Engineer of their crew.

After the equipment on Track No. 1 had moved approximately 700 feet west, the Regulator Operator saw a reflective striped vest in the center of Track No. 1. The Regulator Operator sounded his horn, and the

Assistant Foreman stepped off the track to the north side. As he continued walking west on the maintenance road, the Crew Van Driver was approximately 100 feet behind him on the same road assisting him with his headlights.

The distance from where the ballast was unloaded to where the accident occurred was approximately 1,400 feet. The area where the ballast was unloaded had temporary lighting, provided by portable power plants, while the area west of there, including the accident site, was dark.

The weather at the time of the accident was clear and cold, with a temperature of -5°F.

THE ACCIDENT

The Assistant Foreman had walked approximately 700 feet after clearing Track No. 1 for the regulator, when he abruptly turned and stepped up onto Track No. 1 in front of the tamper. The Tamper Operator's Helper saw the Assistant Foreman's hard hat and called out for the Tamper Operator to stop. The Operator sounded his horn and applied the brakes immediately, but was unable to avoid striking the Assistant Foreman who was standing in between the rails of Track No. 1. The tamper was approximately one-half mile behind the regulator and estimated to have been traveling 5 mph at the time of the accident. The tamper was traveling in the forward direction.

When the tamper came to a complete stop, the Assistant Foreman was under the machine between the rails with no part of the machine touching his body. The three witnesses in the crew van and the two Tamper Operators immediately ran to the Assistant Foreman's aid, but upon reaching him, they determined the injuries to be fatal and notified the Engineer on the ballast train to call for help.

The Gothenburg Rescue Unit was called and responded within 10 minutes of the accident. After viewing the scene, the unit called the Dawson County Sheriff's Department, who arrived a short time later. The Dawson County Deputy Attorney pronounced the Assistant Foreman dead at the scene from a massive head injury.

POST-ACCIDENT INVESTIGATION

In interviews conducted by UP and FRA, investigators determined that a job briefing had been conducted after the ballast was unloaded and before the Assistant Foreman left to check the doors. During the job briefing, the Foreman said that he "told the Assistant Foreman and the guys that were dumping rock to go down and shut the doors on the ballast train." Other employees interviewed indicated they did not know why the Assistant Foreman decided to go alone, although it was not uncommon for one person to perform this routine task. The Conductor was also present during the job briefing and offered the Assistant Foreman the use of his lantern and the headlights of the crew van since it was dark. The Assistant Foreman declined the lantern, but agreed to the headlights. It was also determined through interviews that an updated job briefing was provided when instructions were given to move the equipment to Track No. 1. This information was relayed to the Assistant Foreman via radio from a Supervisor at the derailment site and acknowledged.

Investigators determined that all lights on the tamper were functioning properly at the time of the incident. The Operator had inspected and performed routine maintenance on the machine that morning and took no exceptions to the machine's performance or safety appliances.

The three witnesses in the crew van, who had viewed the final actions of the Assistant Foreman, all agreed that he had failed to look in either direction before crossing the tracks.

No autopsy was performed on the Assistant Foreman. However, the Federally required post-accident toxicological testing was performed on the Assistant Foreman. The test results were negative. The railroad also erroneously collected urine specimens under FRA authority for the Tamper Operator and his Helper. These two sets of specimens were not tested since these personnel were not subject to testing under FRA's regulation found in Title 49 CFR Part 219. This discrepancy in testing has been forwarded to the Operating Practices Specialist in Region 6 for appropriate investigation.

APPLICABLE RULES

General Code of Operating Rules Union Pacific Railroad Company

1.1.2 Alert and Attentive

Employees must be careful to prevent injuring themselves and others. They must be alert and attentive when performing their duties and plan their work to avoid injury.

1.20 Alert to Train Movement

Employees must expect the movement of trains, engines, cars, or other movable equipment at any time, on any track, and in any direction.

Employees must not stand on the track in front of an approaching engine, car, or other moving equipment.

Employees must be aware of the location of structures or obstructions where clearances are close.

81.1.1 Walking On or Near Tracks

Do not stand or sit on, walk fouling of, or walk between rails of track unless required by assigned duties.

When standing, walking, or working between or near tracks, keep a careful lookout in both directions for trains, locomotives, cars or other moving equipment and expect movement at any time, on any track, in any direction. Do not rely on hearing the approach of a train or equipment.

Foremen or others in charge of employees working on or about the tracks must require the employees to be alert and watchful and to keep out of danger.

81.1.2 Precautions Near Passing Trains or Equipment

When near passing trains or equipment:

- Move away from the track to avoid being struck by car doors, protruding or falling articles.

- Stand clear of all tracks when trains are approaching or passing in either direction. Do not stand on one track while trains are passing on an adjacent track.
- Do not allow yourself or others to be next to or between equipment while a train or equipment is closely passing on the adjacent track.
- Do not rely on others to notify you of an approaching train, engine or other equipment unless that person's duties include providing warnings.

Code of Federal Regulations
Title 49, Part 214, Railroad Workplace Safety
Subpart C - Roadway Worker Protection

214.313.01 Roadway worker fouling track when not necessary in the performance of duty.*

*Investigators concluded that if the Assistant Foreman was only crossing the track on which he was struck, then he was not in violation since protection was not needed to only cross a track, as opposed to walking down the tracks or working on them. They established through interviews that he broke this rule earlier when walking down the middle of the track on his way to check the doors, since the maintenance road on the north side provided a safe place to walk.