

SUMMARY OF FE-28-02
SELECTED AND POSSIBLE CONTRIBUTING FACTORS

SELECTED FACTORS

Railroad: CSX Transportation, Incorporated

Location: Cincinnati, Ohio

Region: 2

Month: November

Date: Nov. 15, 2002

Time: 5:20 a.m., EST

Data for All Fatally Injured Employee(s)

Outbound Lead Car Inspector

51 years old

29 years of service

Last rules training: April 1, 2002

Last safety training: April 1, 2002

Last physical: March 25, 2002

Data for All Employees (Craft, Positions, Activity)

Craft: Maintenance of Equipment

Positions:

Assignment for CSX Train No. Q54115

Outbound Lead Car Inspector

Yard Assignment Y33514

Engineer

Other crew members (not specified)

Inbound Lead Car Inspector

Hump Yard Master

Hump Foreman

Activities: Car inspection and switching, simultaneously

EVENT

A Car Inspector was fatally injured when the truck he was driving on the cart path crossing was struck by an auto carrier rail car, the north car of a switching move.

SUMMARY OF FE-28-02 CONTINUED

POSSIBLE CONTRIBUTING FACTORS

PCF No. 1

After their train had been standing idle, the switching crew, as instructed, conducted a “blind shove” move toward the hump at the cart path crossing at the same time the Car Inspector was driving his truck across. The truck and train then collided. ***The Car Inspector did not anticipate the train’s movement; neither were the switching crew members able to see the Car Inspector.***

At the time of the incident, the “blind shove” move was in accordance with the railroad’s operating rules. However, following the incident, a Terminal Superintendent Bulletin was issued ordering Train Directors in the future to announce the shove of a hump cut on the Car Inspector’s radio channel.

PCF No. 2

In non-compliance with the railroad’s operating rules, the Car Inspector was not sufficiently alert for the movement of cars, locomotives, or equipment at any time, in either direction, on any track.

REPORT: FE-28-2002

RAILROAD: CSX Transportation, Incorporated

LOCATION: Cincinnati, Ohio

DATE & TIME: Nov. 15, 2002; 5:20 a.m., EST

EVENT¹: A Car Inspector was fatally injured when the truck he was riding on the cart path crossing was struck by an auto carrier, the north car of a switching move.

EMPLOYEE:

Craft:	Maintenance of Equipment (MOE)
Activity:	Operating Motor Vehicle
Occupation:	Car Inspector
Age:	51
Length of Service:	29 Years
Last Rules Training:	April 1, 2002
Last Safety Training:	April 1, 2002
Last Physical:	March 25, 2002

CIRCUMSTANCES PRIOR TO THE ACCIDENT

On Nov. 14, 2002, the employee went on duty at 11 p.m. at CSX's Queensgate Yard, in Cincinnati, Ohio, as the Outbound Lead Car Inspector. On Nov. 15, 2002, the Lead Car Inspector received instructions to do a set-and-release air brake test on CSX Train No. Q54115. He was informed Q54115 would be stopped on the east open track, where he could have access to the rear of the train. He was operating CSX pick-up truck 90029, equipped for the Outbound Lead Car Inspector, and proceeded south to a location where he could position himself for observation of the rear car of Q54115.

After reaching its destination, inbound Train No. Q51214, which was 4,829 feet long, was left standing on receiving yard Track No. R8, waiting to be humped. The crew of Yard Assignment Y33514 had coupled Locomotives CSXT 2415 and CSXT 1055 to the south end of the cars on Track No. R8, and was preparing to shove them north over the hump. Auto carrier TTGX 976118, the north

¹ "Event" is defined as "occurrence that immediately precedes and directly results in the fatality." Possible contributing factors are identified in the following report and attached summary.

car on Track No. R8, was standing south of a paved cart path that crossed Track No. R8 near the north end.

Inbound freight car inspections were made from motorized carts equipped for that purpose at Queensgate Yard. There were paved paths throughout the yard providing access for the carts. According to a statement made to FRA, TTGX 976118 was standing about half the length of an auto carrier (47 feet) south of the cart path crossing. The Terminal Superintendent's Notice No. 21, dated June 6, 1998, required all transportation crews when yarding trains in the R yard to leave them 25 feet from a cart crossing.

When Train No. Q54115 stopped on the east open track, the rear car of the train was north of the cart path crossing on Track No. R8, and north of the Outbound Lead Car Inspector's position on the south road. He backed his truck north on the South road and backed onto the cart path crossing on Track No. R8. The Engineer of Yard Assignment Y33614, another hump assignment working in the area, observed the truck back onto the cart path crossing and remain there for about a minute. He did not see the truck leave the crossing, and left the immediate area before the accident occurred. It is not known how long the truck remained on the crossing.

At the time the Engineer of Y33614 observed the movement of the pick-up truck, he was moving Locomotives CSXT 2414 and CSXT 1054 from the hump crest to the car shop lead track, then going to lunch. The locomotives were operated south from the crest on the hump lead track until they cleared the switch on Track No. R8 where they could begin their reverse move (north) toward the car shop lead track. When they stopped at the end of the southbound movement, the locomotives were clear of the car shop lead switch, and through the next switch to the south headed toward Track No. R7.

In the area of the accident, the south road was a straight, 1-paved lane, oriented generally north and south. The east open track was immediately next to the east side of the south road, and receiving yard Track No. R8 was immediately to the west. The east open track and Track No. R8 were parallel to the south road in this area.

The receiving yard was illuminated by lights mounted on towers. Visibility of a freight car was several hundred feet when viewed in open areas on a night with similar weather conditions. In areas with rail equipment nearby on both sides (between cars), visibility was reduced.

At the time of the accident, it was dark and cloudy. The temperature was 46° F.

THE ACCIDENT

At about 5:19 a.m. on Nov. 15, 2002, the crew of Yard Assignment Y33514 received instructions from the Train Director to start shoving Track No. R8 toward the hump. The movement toward the hump was a blind shove. When the north car on Track No. R8, Auto Carrier TTGX 976118, reached the cart path crossing, it struck the Outbound Lead Car Inspector's truck on the passenger side and started shoving it north on Track No. R8. The event recorder download from Locomotive CSXT 2415 indicated it was moving at 4 mph at the time of the accident.

Radio broadcast transcripts indicated that at about 5:20 a.m., the Outbound Lead Car Inspector called on the Car Inspector's radio channel (20) to stop the movement on Track No. R8. This transmission was heard by the Inbound Lead Car Inspector, who phoned the Hump Yard Master. The Hump Yard Master monitored a different radio channel. The Hump Yard Master called the Hump Foreman and notified him to stop the movement on Track No. R8. At about 5:21 a.m., the Hump Foreman notified the Engineer on Train No. Y33514 to stop, and he took immediate action to do so. The Engineer was operating Train No. Y33514's locomotives manually at the time of the accident. They were not placed in automatic hump control at any time prior to or during the accident.

Before the shoving movement came to a stop, the Car Inspector's truck was shoved about 360 feet north of the cart path crossing before coming to rest upside-down, underneath the north end of TTGX 976118, and was on fire. The Car Inspector was severely injured and ejected from the vehicle about 20 feet south of where it came to rest. The Cincinnati Fire Department, Cincinnati Police Department, and Hamilton County Coroner responded to the accident. At 9:45 a.m., the Coroner pronounced the Car Inspector dead and transported his body from the accident site.

POST-ACCIDENT INVESTIGATION

FRA's post-accident investigation included compliance evaluations of applicable rules pertaining to the operation of Train No. Y33514, operation of the motor vehicle, and gathering necessary documentation.

The accident was investigated by CSX, FRA, the Ohio Public Utilities Commission, the Cincinnati Fire Department, the Cincinnati Police Department, and the Hamilton County Coroner.

The Coroner's report established the cause of death as an exsanguinating hemorrhage due to a crushing injury to the torso. Federal post-accident toxicological tests were made on the deceased, the crew of Y33514, and the Train Director on duty at the time of the accident. Results were negative.

APPLICABLE RULES

Publication - CSXT Safe Way, Engineering & Mechanical Departments, 2002 **Section - On Or About Tracks**

Rule 16 : When working on or about tracks:

- a) Be alert for the movement of cars, locomotives, or equipment at any time, in either direction, on any track.

Although the movement to the hump was made as a blind shove, Train No. Y33514 was being operated in accordance with CSX Operating Rules.

After the accident, a Terminal Superintendent Bulletin was issued ordering the Train Director to announce the shove of a hump cut on the Car Inspector's radio channel.