

**SUMMARY FOR FE-22-03**  
**SELECTED AND POSSIBLE CONTRIBUTING FACTORS**

**SELECTED FACTORS**

**Railroad:** Georgia Central Railway Company  
**Location:** Dublin, Georgia  
**Region:** 3

**Month:** September  
**Date:** Sept. 12, 2003  
**Time:** 11:45 a.m., EST

**Data for Fatally Injured Employee(s)**

Conductor  
45 years old  
**2 months of service**  
Last rules training: Aug. 15, 2003  
Last efficiency test: Aug. 25, 2003  
Last physical: July 3, 2003

**Data for All Employees (Craft, Position, Activity)**

**Craft:** Transportation and Engine

**Positions:**

**Georgia Central Industry Switcher, Y103**

Engineer  
Conductor

Foreman  
Train Dispatcher

**Activity:** Switching

**EVENT**

A Conductor was fatally injured when crushed between two rail cars during a switching movement.

**SUMMARY FOR FE-22-03 CONTINUED**

**POSSIBLE CONTRIBUTING FACTORS**

**PCF No. 1**

The Conductor failed to remain clear of moving equipment, in non-compliance with the railroad's operating rules.

**PCF No. 2**

The Conductor had completed an operating rules exam a month before the incident, had participated in eight safety meetings since his employment two months prior to the incident, and had performed well during efficiency tests. However, with only two months employment, the Conductor was very inexperienced.

**REPORT:** FE-22-2003

**RAILROAD:** Georgia Central Railway Company (GC)

**LOCATION:** Dublin, Georgia

**DATE & TIME:** Sept. 12, 2003; 11:45 a.m., EST

**EVENT<sup>1</sup>:** The Conductor was fatally injured when crushed between two rail cars during a switching movement.

**EMPLOYEE:**

Craft:	Transportation and Engine (T&E)
Activity:	Switching
Occupation:	Conductor
Age:	45 years
Length of Service:	2 Months
Last Rules Training:	Aug. 15, 2003
Last Efficiency Test:	Aug. 25, 2003
Last Physical:	July 3, 2003

### **CIRCUMSTANCES PRIOR TO THE ACCIDENT**

On Sept. 12, 2003, a 2-person crew (Conductor and Engineer) was called to operate Georgia Central (GC) Industry Switcher, Y103. The crew reported for duty at 7 a.m., EST, at the Southeast Paper Mill (SEP) in Dublin, Georgia. Both crew members received a statutory off-duty period of more than 12 hours at their home terminal prior to reporting for duty. After reporting for duty, the crew inspected the locomotive, called the various SEP docks to confirm their work orders, and conducted a job briefing. Y103's first move was to shove eight outbound loads to the main track located 3/4 of a mile west of SEP. The crew switched the Mohawk and Clay docks, then called the Foreman on the No. 2 dock, and pulled five loads from the dock. Y103 departed SEP with 17 cars, coupled to the eight cars they left on the main track, and pulled west to Dublin Yard.

The weather was clear, and the temperature was 78° F.

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<sup>1</sup> “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.

## **THE ACCIDENT**

Y103 pulled to the main track switch at the west end of Dublin yard with 25 cars. The Engineer was operating lead locomotive GC 3968 from the south side, short hood forward. The Conductor dismounted the lead locomotive from the north side at the main track switch. After stopping Y103 clear of the main track switch, the Conductor removed the west derails on the No. 1 and No. 2 storage tracks. The Conductor lined the storage track switch for the No. 2 storage track, then lined the main track switch for movement toward the storage tracks.

After lining the switches, the Conductor instructed Y103 to pull ahead a couple of car lengths. The Engineer began to pull ahead in a westward direction when the Conductor said, "Hold up, what are you doing?" The Engineer responded, "You told me to pull ahead." The Conductor then stated, "No, I meant shove back about four or five car lengths." The Engineer acknowledged the instruction and began shoving back in an eastward direction. The move was to couple to freight cars standing on the No. 2 storage track.

After shoving back in an eastward direction for about 1 ½ car lengths, the Engineer called the Conductor on the radio and received no response. The Engineer called again and when there was still no response, he brought the train to a stop. When he called again and received no response, he dismounted the locomotive and walked back to see what was wrong. When he got to the rear of the train, the Engineer found the Conductor's body cut in half, lying on the north side of the main track. The accident occurred about 11:45 a.m.

The Engineer ran back to the locomotive and radioed the GC Dispatcher in Vidalia, Georgia. He advised the Train Dispatcher of the accident and said emergency response personnel were needed at Dublin Yard. The Laurens County Sheriff's Department and the Laurens Emergency Medical Service arrived at the accident site about 12:24 p.m. The body was taken to the Fairview Park Hospital Morgue, where a screening of the body was conducted by the Laurens County Deputy Coroner. The body was later transported to the Georgia Bureau of Investigation's State Laboratory in Atlanta, Georgia, where an autopsy was performed.

## **POST-ACCIDENT INVESTIGATION**

The Conductor started working for GC in July 2003, as a Conductor Trainee. His on-the-job training was with the train crew of Y103. GC qualified him as a Conductor in August and assigned him to Y103 as the Conductor.

The primary duties of Train Y103 were to service SEP and build an east and west bound pickup at Dublin Yard. This was a 7-day per week assignment from 7 a.m. to 3 p.m.

Dublin Yard was located on the GC Macon Subdivision, at milepost 57. The accident occurred at milepost 56.9. The yard was in a remote wooded area and comprised two storage tracks located on the north side of the main track. Both storage tracks had the capacity to hold

approximately 27 cars. The method of operation was Yard Limits with an operating speed of 10 mph.

The investigation revealed the Conductor was struck by the brake end (B-end) of the lead car, CSXT 150181. Blood stains were found on the right number one and number two wheels. The Engineer brought the train to a stop approximately three and a half car lengths east of the accident site. The body was located at about 11 feet, 5 inches west of the main track switch. Both halves of the body were found on the north side of the rail. The Conductor's hat was found between the rails near the body. There were no tape recordings of radio transmissions, and the locomotive was not equipped with an event recorder. The Engineer estimated the shoving speed at the time of the accident to be approximately 3 mph. The GC track and mechanical departments found no defects on the car involved in the accident or the track in the accident area.

The Conductor completed his operating rules exam on August 15, and had participated in eight safety meetings since his employment. GC personnel records revealed that the carrier had conducted efficiency tests of the Conductor's performance on August 25. The tests covered several categories including switching, switches, and working around moving equipment. There were no deficiencies recorded.

Post-accident toxicology tests were negative for drugs and alcohol on both crew members.

### **APPLICABLE RULES**

The Conductor was in violation of Georgia Central operating rule 70.32.4: Sufficient Distance. This rule states the following:

Employees must maintain a safe distance from equipment and not:

1. Cross or step foul of tracks closely in front of or behind moving equipment;
2. Go between equipment if the opening is less than one car length; or
3. Cross tracks in front of or behind standing equipment unless there is at least 20 feet between the employee and the equipment.