

**SUMMARY FOR FE-04-03**  
**SELECTED AND POSSIBLE CONTRIBUTING FACTORS**

**SELECTED FACTORS**

**Railroad:** CSX Transportation, Incorporated  
**Location:** East Syracuse, New York  
**Region:** 1

**Month:** February  
**Date:** Feb. 16, 2003  
**Time:** 12:24 a.m., EST

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

Switchman (Secondary Remote Control Operator)  
36 years old  
2 ½ years of service  
Last rules training: April 20, 2002  
Last safety training: April 6, 2002  
Last physical: N/A

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

**Craft:** Transportation and Engine

**Positions:**

**Yard Assignment Y-390-15**

Fatally injured Switchman (Secondary Remote Control Operator)  
Foreman (Primary Remote Control Operator)

Yard Master

**Activity:** Switching

**EVENT**

A Switchman was fatally injured when he slipped or fell in front of  
an approaching freight car which ran over him.

**SUMMARY FOR FE-04-03 CONTINUED**

**POSSIBLE CONTRIBUTING FACTORS**

**PCF No. 1**

For reasons unknown, the fatally injured Switchman fell across the south rail of the north drill track as the kicked car approached, running over him.

**PCF No. 2**

The Switchman may have slipped on the layer of snow and ice on the ground from a previous snow fall.

**REPORT:** FE-04-2003

**RAILROAD:** CSX Transportation, Incorporated (CSX)

**LOCATION:** East Syracuse, New York

**DATE & TIME:** Feb. 16, 2003; 12:24 a.m., EST

**EVENT<sup>1</sup>:** A Switchman was fatally injured when he slipped or fell in front of an approaching freight car which ran over him.

**EMPLOYEE:** Craft: Transportation and Engine (T&E)

Activity: Switching

Occupation: Switchman (Secondary Remote Control Operator)

Age: 36 years

Length of Service : 2½ years

Last Rules Training: April 20, 2002

Last Safety Training: April 6, 2002

Last Physical: N/A

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

On Feb. 16, 2003 at 12:24 a.m., a CSX employee was fatally injured while performing remote control locomotive switching operations at the railroad's Dewitt Yard in East Syracuse, New York. Dewitt Yard is a major freight car classification yard located on the railroad's east/west (timetable direction) Chicago Main Line between M.P. 283.8 and M.P. 286.0 on CSX's Albany Service Lane. Yard movements within Dewitt Yard are made at "restricted speed," not exceeding 10 mph.

On Feb. 15, 2003, the employee was assigned to the railroad's "extra list". Following the statutory time-off period, he was called to work as the Secondary Remote Control Operator for Yard Assignment Y-390-15, which also comprised a Primary Remote Control Operator (Foreman). Each crew member was equipped with an operator control unit to operate the assigned remote controlled locomotives. The two men reported for duty at the rail yard's east end crew room prior to their 11 p.m. on-duty time. After a brief conversation, the Foreman

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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.

walked to the east end tower to receive a job briefing and a switch list from the Yard Master. While the Foreman was at the tower, the Switchman inspected and set up their assigned locomotives (CSX 2543 and CSX 2766) for remote control operation.

The two men met back at the crew room where the Foreman conducted a job briefing. They discussed the weather conditions and the need to take frequent breaks during the shift because of the cold temperatures.

At approximately 11:25 p.m., the crew members tested their remote control equipment in accordance with CSX company rules. They performed a “vigilance test,” a “standing brake test,” and a “running brake test.” At 11:42 p.m., they performed a “tilt feature” test which was acknowledged by the Yard Master via 2-way radio. No exceptions to the equipment were noted by either crew member.

The crew members began performing their routine switching activities at the east end of the classification yard at approximately 11:45 p.m. The Foreman operated the remote control locomotives from his operator control unit while the Switchman aligned switches to direct cars onto various tracks. They were working approximately 500 feet apart and communicated via 2-way radios. The Foreman first coupled the locomotives to the east end of nine cars on Track No. 18 and switched them to Track No. 20 where they were coupled to 16 additional cars. The 25 cars were then pulled out onto the north drill lead (a.k.a. “ladder track”) to be switched to various tracks according to the switch list. While the Foreman completed moves onto Track No. 15 and Track No. 16, he instructed the Switchman to align switches for Track No. 6 and Track No. 2. After they left one car (SM 3131) on Track No. 15 and four cars (WC 24098, WC 28162, WC 28043 and KCS 752789) on Track No. 16, the next car on the switch list (CSX 138276) was destined for Track No. 6. The crew used a common railroad switching practice known as “kicking” to switch the cars to various tracks. “Kicking” refers to the practice of shoving and releasing cars, allowing them to roll free (coast) onto the designated track. Once the car had cleared the switch onto Track No. 6, the Switchman was to re-align the switches for a single car destined for Track No. 2.

At 12:13 a.m., the Switchman radioed the Foreman and asked whether he had any aspirin in his locker. The Foreman responded, “...do you need it now?” The Switchman then replied, “No, I can wait.” At 12:20 a.m., the Switchman told the Foreman via radio, “After this car goes to six, ... I’m gonna walk up...I gotta get some water out of the penalty box there.” The “penalty box” is a small “shanty” used by crew members to get out of the weather. The Foreman acknowledged by saying, “Yeah, okay.” As the Foreman was pulling the cut of cars out of Track No. 16 onto the north drill lead, he observed the Switchman standing in the clear of the north drill lead, in the walkway between the switch for Tracks Nos. 6 and 7. At 12:22 a.m., the Foreman radioed the Switchman, “Coming back for 6.” The Switchman acknowledged, “Roger.” The Foreman attempted to “kick” the car (CSX 138276) toward Track No. 6. He pulled the uncoupling lever on the car, but the knuckle pin dropped and the car failed to uncouple. He stopped the movement, uncoupled the car and closed the two knuckles between the cars. He then shoved against the car and sent it down the ladder track toward the Switchman’s position at the Track No. 6 switch.

At the time of the accident, the sky was clear, and the temperature was -15° F. There was a layer of snow and ice on the ground from a previous snow fall.

### **THE ACCIDENT**

At 12:24 a.m., the Foreman's operating control unit indicated a "no poll" failure and had lost continuity with the remote control unit installed on the locomotive. Because of this loss of continuity, the remote control locomotive (CSX 2543) went into a penalty brake application, a power knockdown occurred, and the throttle went to idle.

The Foreman radioed the Switchman asking, "Did you turn off the box by accident?" There was no response from the Switchman. The Foreman tried unsuccessfully several more times to contact the Switchman as he walked toward the Switchman's last known location. The Foreman was approximately 300 feet east of the Track No. 6 switch when he observed the Switchman lying across the south rail of the north drill track. The Foreman radioed the Yard Master to call "911." Local ambulance and emergency medical responders arrived at approximately 12:35 a.m., followed by police and fire departments.

### **POST-ACCIDENT INVESTIGATION**

Officials of the Federal Railroad Administration (FRA), New York State Department of Transportation, Town of Manlius, New York Police Department, Onondaga County Medical Examiner's Office, and CSX conducted investigations of the employee fatality. There were no eye-witnesses to the accident. Police investigators concluded the fatality was accidental.

FRA investigators concluded that for reason(s) unknown, the employee fell across the south rail of the north drill track, as the kicked car approached. The employee was unable to recover before being run over by the moving freight car. The employee was found face up with his upper torso inside the gauge of the track and his lower torso and legs outside the gauge.

Post-accident inspection of the involved on-track equipment revealed no defective condition(s) that caused or contributed to the accident. Data from the event recorder installed on locomotive CSX 2766 (Quantum-SN 94060005) was downloaded by CSX personnel and the relevant data reviewed. Data indicated the maximum recorded speed of the locomotive, prior to releasing car CSX 138276, was 10 mph.

The area where the accident occurred was well lighted, with illumination provided by flood lights installed on several poles in the immediate area.

Federal post-accident toxicological tests of the deceased were negative.

A forensic autopsy conducted by the Onondaga County Medical Examiner's Office, dated Feb. 17, 2003, indicated the manner of death as "accident," and the cause of death as "blunt force injuries of the trunk due to: train versus pedestrian accident." Comments indicated: "No other significant injuries are present, and no significant natural disease is evident."

### **APPLICABLE RULES**

#### **CSX Safety Rule 2051: Working On or About Tracks**

When working on or about tracks:

- Be alert for and keep clear of the movement of cars, locomotives, or equipment at any time, in either direction, on any track;
- Stand at least 30 feet from a switch or derail associated with the route of a passing train, and 10 feet, when practical, from a switch or derail being traversed by engines or cars during switching operations; and
- Look in both directions before making any of the following movements:
  - Fouling or crossing a track;
  - Moving from under or between equipment;
  - Getting on or off equipment; or
  - Operating a switch.