

REPORT: FE-10-97
RAILROAD: Consolidated Rail Corporation (CR)
LOCATION: Newark, New Jersey
DATE, TIME: March 21, 1997, 7:15 p.m., EST

PROBABLE CAUSE:

The Carman failed to maintain proper vigilance for moving railroad equipment while fouling unprotected track.

POSSIBLE CONTRIBUTING FACTOR:

Lack of communication between the Carman, the Yardmaster, and Train Crew Members.

EMPLOYEE: **Craft..... Maintenance of Equipment**

Activity..... Inspection of 72 cars for outbound train and switching at the same time.

Occupation..... Car Inspector (Carman)

Age..... 55 years

Length of Service..... Two years, nine months

Last Rules Training..... March 20, 1997

Last Safety Training..... March 21, 1997

Last Physical Exam..... March 11, 1997

Circumstances Prior to the Accident

At 3 p.m., on Friday, March 21, 1997, a Conrail (CR) employee (deceased) reported for his regularly assigned duties as a Car Inspector (Carman) on the 3 p.m. to 11 p.m. shift at the railroad's Oak Island Yard in Newark, New Jersey. The Carman had returned to work the previous day (Thursday, March 20) following an extended absence from work due to an on-the-job shoulder injury he had sustained on July 17, 1995. Including this extended absence from work, his total experience with CR was two years, nine months. The Car Inspector had previously been employed as a Brakeman by the New Jersey Transit Rail Operations (passenger trains only) from Jan. 10, 1994 through Sept. 16, 1994. Following a routine job briefing

conducted by the Carman's Supervisor (Foreman), he began his normal work activities.

At approximately 6:30 p.m., the Carman and a co-worker were assigned to inspect 72 cars for outbound Train OIAL-7, located on Track No. 7 in the receiving yard. The receiving yard was a clear, open area with tracks running in an east/west timetable direction. There was an access road parallel to Track No. 7 to the south side and an adjacent track (Track No. 8) to the north. As instructed, the two Carmen proceeded to the receiving yard by truck and, after applying Blue Signal protection to both ends of Track No. 7, began walking the cars from opposite ends of the track and on opposite sides of the cars. The Carman began walking eastbound between Tracks Nos. 7 and 8 while his co-worker walked westbound along the access road. At approximately the mid-way point of the 72-car train, the two Carmen met one another and, following a brief conversation, continued their inspection. At some point after the two Carmen resumed their inspection, the co-worker heard a locomotive pass his location traveling eastward on Track No. 8.

On the day of the accident, the Crew for Switch Job YPOI-31 at Conrail's Oak Island Yard reported for duty at 3:45 p.m. The Crew comprised an Engineer, Conductor, and Brakeman. At approximately 6:45 p.m., the Switch Crew received instructions from the Yardmaster to couple onto four cars located near the west end of Track No. 8 and shove them to a coupling with a tank car located near the east end of the track. The Conductor proceeded on foot to the east end of Track No. 8 to position himself at the tank car, while the Brakeman stayed with the locomotive to couple the four cars at the west end of the track. After coupling to the four cars and releasing the handbrakes, the Brakeman returned to the locomotive and positioned himself in the Fireman's seat opposite the Engineer (south side). The Engineer contacted the Conductor by radio and informed him that they were shoving the four cars eastward toward him. The locomotive headlight was on dim, and the bell was ringing. The shoving movement was made at an estimated speed of between 5 and 10 mph.

The weather at the time of the accident was clear and cold with a temperature of 40° F. It was dark at the time of the accident (7:15 p.m.). There was no artificial lighting in the area.

The Accident

There were no eye-witnesses to the accident. Upon reaching the west end of the 72 cars on Track No. 7, the co-worker attempted several times to contact the Carman by radio. Receiving no answer, he began walking eastward toward the opposite end of the track in search of the Carman. At some point, he radioed the Foreman to inform him of the missing employee. The Foreman notified the Yardmaster to stop all train movements in the yard, and he and another Carman proceeded to the receiving yard to assist in the search.

At approximately 8:00 p.m., the Carman was found fatally injured lying between Tracks Nos. 7 and 8. Evidence indicates that the Carman was struck in the back and left shoulder by the moving equipment traveling east on Track No. 8. His right arm was severed above the elbow by the wheels of the passing equipment. While awaiting the arrival of the emergency responders

from University Hospital in Newark, NJ, the Foreman performed CPR to no avail. The Carman was pronounced dead at 8:54 p.m., and the body was removed from the scene at 11:38 p.m.

Please see the attached diagram of the Oak Island Yard to better visualize the accident scene and the chain of events that led up to the fatality.

Post-Accident Investigation

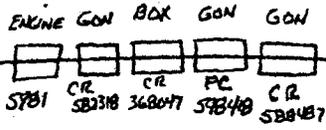
Federal Railroad Administration (FRA) investigators inspected the equipment involved and found no defective conditions that would have contributed to the cause of the accident. There were no lading or other protruding parts of the cars which could have struck the deceased. No exceptions were taken to the condition of the locomotive. A re-enactment of the shoving movement was conducted the following day to determine at what point an individual located on the ground between Tracks Nos. 7 and 8 could be seen from the locomotive cab. Due to the right-hand curvature of Tracks Nos. 7 and 8, the end of the leading car could not be seen from either side of the locomotive cab during the backward shoving move.

Post-accident interviews revealed that the Engineer and the Brakeman were unaware that the equipment had struck the Carman. The Conductor, who was positioned at the west end of the tank car awaiting the arrival of the shoving movement, did not see the accident either.

The New Jersey State Toxicology Laboratory at the Edwin H. Albano Institute of Forensic Science performed post-accident blood and urine toxicology tests. The test results were negative. Post-accident toxicology testing was also performed under FRA authority by northwest Toxicology Inc. at Salt Lake City, Utah. The results of those tests were also negative. The New Jersey State Medical Examiner's autopsy report indicated the cause of death was "multiple blunt force injuries."

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WEST



DIRECTION OF TRAIN

TANK

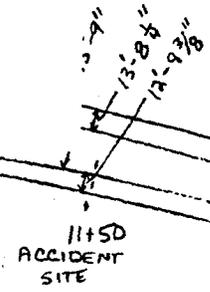
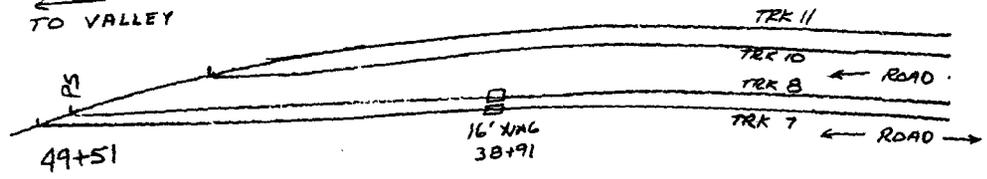
GLNY 23017

EAST

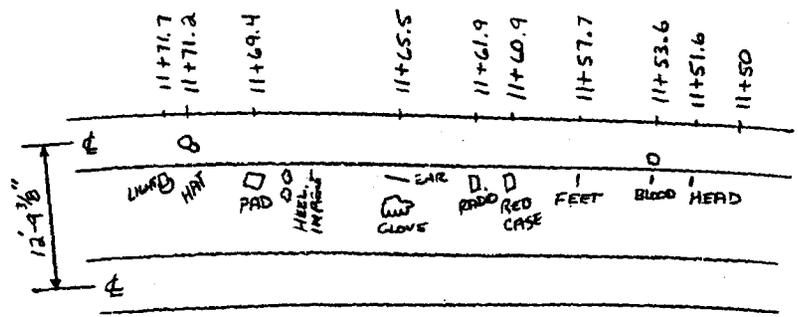
TRK 8



WEST
TO VALLEY



EAST
TO HUMB



ACCIDENT SITE DETAIL

0+00 - DISTANCE IN FEET
 CL - CENTER LINE
 PS - SWITCH POINT

OAK ISLAND YARD
 NEWARK, NJ
 ACCIDENT SURVEY
 TRK 8 RECEIVING YARD
 3-21-97 FXG
 NO SCALE