

INTERSTATE COMMERCE COMMISSION  
WASHINGTON

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INVESTIGATION NO. 2814  
THE NEW YORK, NEW HAVEN AND HARTFORD  
RAILROAD COMPANY  
REPORT IN RE ACCIDENT  
AT STANDISH, MASS., ON  
AUGUST 5, 1944

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SUMMARY

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Railroad: New York, New Haven and Hartford  
Date: August 5, 1944  
Location: Standish, Mass.  
Kind of accident: Derailment  
Train involved: Passenger  
Train number: 811  
Engine number: 1336  
Consist: 4 cars  
Estimated speed: 50 m. p. h.  
Operation: Timetable, train orders and  
manual-block system  
Track: Single; tangent; 0.045 percent  
descending grade southward  
Weather: Cloudy  
Time: About 3:26 p. m.  
Casualties: 2 killed; 45 injured  
Cause: Train entering open switch at  
high rate of speed

INTERSTATE COMMERCE COMMISSION

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INVESTIGATION NO. 2814

IN THE MATTER OF MAKING ACCIDENT INVESTIGATION REPORTS  
UNDER THE ACCIDENT REPORTS ACT OF MAY 6, 1910.

THE NEW YORK, NEW HAVEN AND HARTFORD RAILROAD COMPANY

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August 26, 1944.

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Accident at Standish, Mass., on August 5, 1944, caused  
by a train entering an open switch at a high rate  
of speed.

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REPORT OF THE COMMISSION<sup>1</sup>

PATTERSON, Chairman:

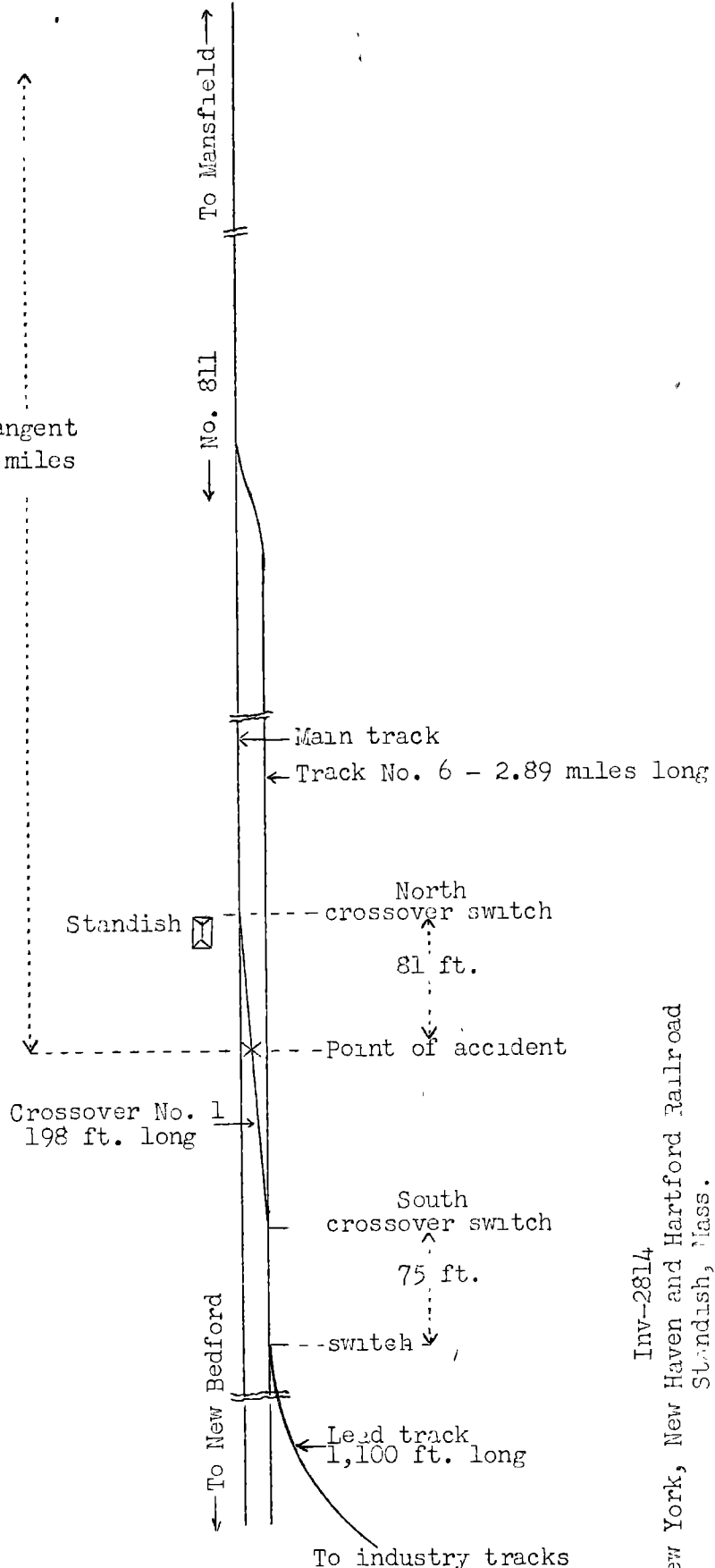
On August 5, 1944, there was a derailment of a passenger train on the New York, New Haven and Hartford Railroad at Standish, Mass., which resulted in the death of 2 train-service employees, and the injury of 42 passengers and 3 train-service employees. This accident was investigated in conjunction with a representative of the Massachusetts Department of Public Utilities.

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<sup>1</sup>Under authority of section 17 (2) of the Interstate Commerce Act the above-entitled proceeding was referred by the Commission to Chairman Patterson for consideration and disposition.

- o Mansfield, Mass. 4.68 mi.
- o Norton 3.54 mi.
- X Standish (P. of A.) 22.86 mi.
- o New Bedford, Mass.

Tangent 5 miles



Inv-2814  
 New York, New Haven and Hartford Railroad  
 Standish, Mass.  
 August 5, 1944

Location of Accident and Method of Operation

This accident occurred on that part of the Boston Division extending southward from Mansfield to New Bedford, Mass., 31.08 miles. In the vicinity of the point of accident this was a single-track line over which trains were operated by timetable, train orders and a manual-block system. In the vicinity of Standish, 8.22 miles south of Mansfield, an auxiliary track, 2.89 miles long and designated as track No. 6, paralleled the main track on the east. At Standish the north switch of a No. 10 crossover 198 feet long, hereinafter referred to as crossover No. 1, which connected the main track and track No. 6, was opposite the station. Crossover No. 1 was facing-point for south-bound movements from the main track to track No. 6. A lead track about 1,100 feet long extended southeastward from track No. 6 to several industry tracks, and its north switch was 75 feet south of the south switch of crossover No. 1. The accident occurred on crossover No. 1 at a point 81 feet south of the north switch. The main track was tangent throughout a distance of about 5 miles north of Standish and a considerable distance southward. At the point of accident the grade for south-bound trains was 0.045 percent descending.

The switches of crossover No. 1 were hand-operated, and were in the charge of a switchtender. The switch-stand of the north switch of crossover No. 1 was of the hand-throw, intermediate-stand type, and was provided with an oil lamp and two targets. The centers of the lenses and the targets were, respectively, 6 feet 7 inches and 5 feet above the ties, and about 7 feet west of the gage side of the west rail of the main track. When the switch was lined normally a green circular target, 15 inches in diameter, and a green light were displayed. When the switch was lined for movement through the crossover a red arrow-shaped target, 14-1/2 inches by 15 inches, and a red light were displayed.

Operating rules read in part as follows:

104. \* \* \*

Where trains are required to be reported clear of main track, at hand operated switches, such report must not be made until switch has been secured in its normal position.

104a. The normal position for all switches \* \* \* is that which leaves the main track clear for the safe passage of trains or engines.

\* \* \*

The maximum authorized speed for passenger trains was 60 miles per hour.

### Description of Accident

No. 811, a south-bound passenger train, consisted of engine 1336, of the 4-6-2 type, one baggage car and three coaches, in the order named. The second and third cars were of all-steel construction and the remainder were of steel-underframe construction. This train passed Norton, 3.54 miles north of Standish and the last open office, at 3:22 p. m., on time, and while moving at an estimated speed of 50 miles per hour it entered crossover No. 1 at Standish and was derailed.

The engine and the first three cars were derailed. The engine and tender stopped on their left sides on the lead track and in line with it, with the front end of the engine 514 feet south of the point of derailment. Both were badly damaged. The first three cars stopped practically upright and in line with the lead track. The first two cars were considerably damaged and the third car was slightly damaged.

It was cloudy at the time of the accident, which occurred about 3:26 p. m.

The engineer and the fireman were killed. The baggageman, the ticket collector and the flagman were injured.

### Discussion

No. 811 was moving on tangent track at an estimated speed of 50 miles per hour, in territory where the maximum authorized speed was 60 miles per hour, when it entered crossover No. 1 at the north switch at Standish. The engine and the first three cars were derailed. As the train was approaching Standish the conductor was in the second car and the other members of the train crew were in other cars of the train. The first these employees knew of anything being wrong was when the brakes were applied in emergency just prior to the derailment. Examination immediately after the accident disclosed that the north switch of crossover No. 1 was lined for entry to the crossover. It could not be determined when the enginemen first became aware that the switch was improperly lined, as they were killed in the accident. Because of buildings, the foliage of trees and street crossing signals adjacent to the track in the vicinity of the north crossover-switch, the switch target was visible from a distance of only a few hundred feet.

The investigation disclosed that about 40 minutes prior to the occurrence of the accident the switchtender lined the switches of crossover No. 1 for the movement of a south-bound extra train through the crossover. After the movement was completed the switchtender restored the south switch to its normal position, then proceeded toward the north switch. When he had reached a point a short distance south of the north switch the bell of a telephone in the station sounded, and he entered the station to answer the telephone. After the conversation on the telephone was finished, he remained in the station, where he cleaned lanterns and then listened on the telephone. He understood that, under the rules, main track switches were required to be secured in normal position before any train was reported to be clear of the main track. However, in this case, he forgot that the north switch of crossover No. 1 had not been restored to its normal position, and, about 2:56 p. m., he informed the operator at Norton that the extra train had cleared the main track. He first realized that the switch was improperly lined when the engine of No. 811 entered the crossover.

During the 30-day period preceding the day of the accident, there was a daily average of 18.9 trains operated over this line. The daily average of passenger trains was 12.16. In view of the maximum authorized speed of 60 miles per hour in this territory, the volume and type of traffic, and the fact that the manual block system does not provide protection against open switches, the attention of operating officials of this railroad is directed to the need for measures which will provide greater protection against accidents resulting from open switches.

Cause

It is found that this accident was caused by a train entering an open switch at a high rate of speed.

Dated at Washington, D. C., this twenty-sixth day of August, 1944.

By the Commission, Chairman Patterson.

(SEAL)

W. P. BARTEL,  
Secretary.