

Inv-2201

INTERSTATE COMMERCE COMMISSION
WASHINGTON

Dept. of Transportation

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REPORT OF THE DIRECTOR
BUREAU OF SAFETY

ACCIDENT ON THE
NEW YORK, ONTARIO & WESTERN RAILWAY

MIDDLETOWN, N.Y.

SEPTEMBER 28, 1937

INVESTIGATION NO. 2201

SUMMARY

Inv-2201

Railway: New York, Ontario & Western
Date: September 28, 1937
Location: Middletown, N.Y.
Kind of accident: Yard collision
Trains involved: Switch engine backing ; Cars standing
up and shoving caboose ; on receiving
: track 5
Engine numbers: Yard engine 307 : --
Speed: 5-7 m.p.h. : Standing
Track: Tangent; grade 0.3 percent ascending
northward
Weather: Misting
Time: 2:07 p.m.
Casualties: 1 killed; 2 injured
Cause: Improperly lined yard switch

October 25, 1937.

To the Commission;

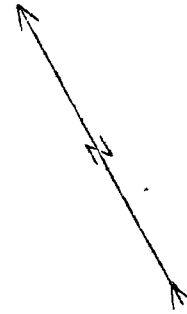
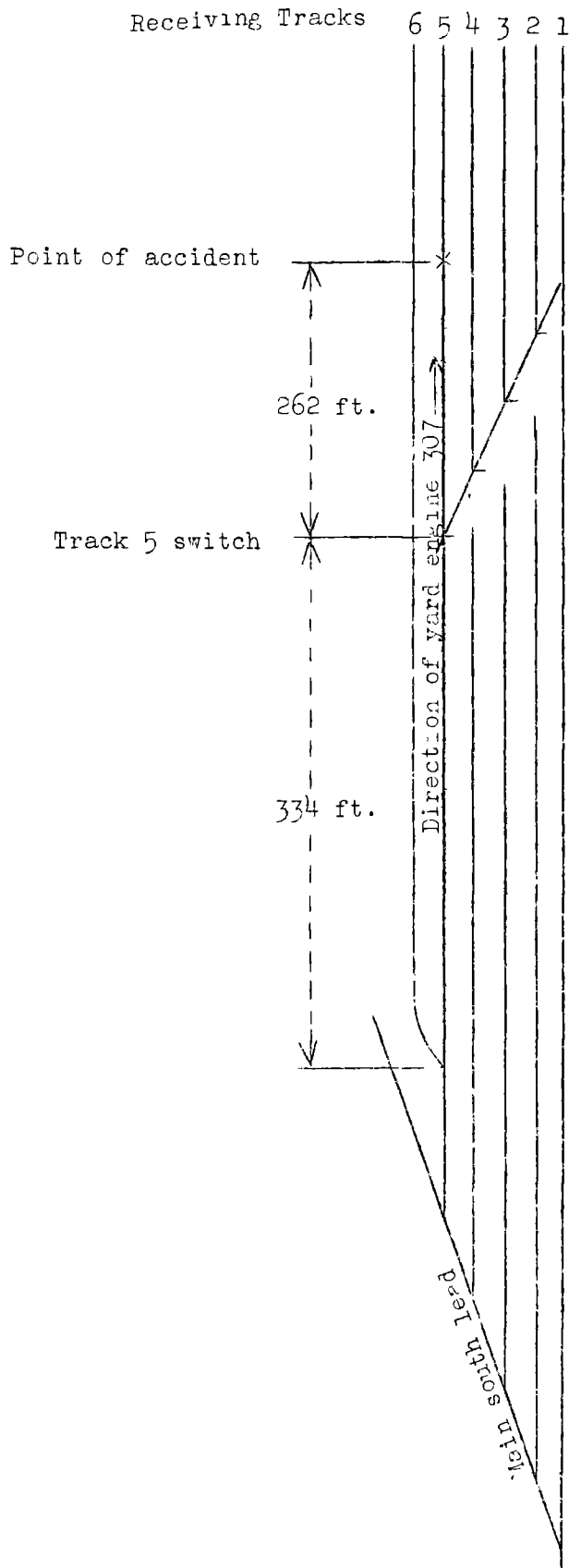
On September 28, 1937, there was a collision between a caboose being shoved ahead of a yard engine backing up and a cut of cars standing on a track in the yard of the New York, Ontario & Western Railway at Middletown, N.Y., which resulted in the death of one employee and the injury of two employees.

Location and method of operation

The accident occurred on the Southern Division, in Middletown yard which comprises several groups of tracks and other terminal facilities. One of these groups, consisting of five parallel tangent tracks, approximately 2,700 feet long and served by the same north and south leads, is known as the receiving yard. The lead at the south end of receiving tracks 1 to 4 branches off track 5 at a point about 400 feet north of the junction point of that track with the main south lead of Middletown yard. From this main south lead entry is also provided to the caboose storage track. The accident occurred on receiving track 5 at a point 262 feet north of the receiving yard lead switch. Approaching from the south the receiving tracks are tangent; the grade on track 5 is practically level for 200 feet, then it is approximately 0.3 percent ascending northward to the point of accident.

The switch stands are located on the east side of the lead track, and the switch stand to receiving track 5 is a Ramapo #19 stand. Flanges $2\frac{1}{2}$ inches wide around the roundels of the switch lamp painted yellow and green to correspond with the color of the lenses serve as day route indicators. The lenses are $3\frac{1}{2}$ inches in diameter and the centers of the lenses are $33\frac{1}{2}$ inches above the switch ties and 6 feet $1\frac{1}{2}$ inches from the center of the track. A yellow indication is displayed when the switch is lined for track 5, and a green indication when lined for the lead track. The flanges of the switch lamp were somewhat dirty and dull, but the indications could be distinguished from the point at which the northward movement that resulted in the accident started.

At the time of the accident 52 cars, composing the make-up of Train AW-2, were standing on track 5, with the hand brakes set on about 10 of the cars at the south end; track 4 was unoccupied.



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Movements are made in accordance with yard rules, under the supervision of a yard master. Rule 102 provides that when cars are pushed by an engine, except when shifting or making up trains in yards, a trainman must take a conspicuous position on the front end of the leading car. A general order prohibited riding on the leading footboard of yard engines.

There was a light rain falling at the time of the accident, which occurred about 2:07 p.m.

Description

Yard engine 307 was in charge of Conductor Taylor and Engineman Boyce. In the course of a yard movement it moved southward through receiving track 4, thence along the lead track to the caboose track, where caboose 8340 was switched out. Engine 307 then coupled to the south end of the caboose and started on a movement northward which ended in a collision with the cars standing on track 5, at a point 262 feet north of track 5 switch.

The force of the impact raised the caboose off the track and it was somewhat damaged, as was also yard engine 307 and the first of the standing out of cars. The employee killed was a trainman, who apparently was on the north footboard of engine 307, between the tender and caboose, and the employees injured were the conductor and a trainman who were on the south platform of the caboose.

Summary of evidence

Conductor Taylor, of yard engine 307, stated that he has had 18 years of service in the yard at Middletown. In accordance with instructions he had taken his engine from the north end of the yard through track 4 to the caboose track at the south end of the yard to get caboose 8340 which was to be placed on the north end of Train AW-2 in track 5. On the return movement with the engine backing up and shoving the caboose, Conductor Taylor and Trainman Johnson stood on the west side of the south platform of the caboose talking about the work that was to be performed; during this conversation the caboose entered receiving track 5 and struck the standing cars while moving at a speed of about 6 miles per hour. Conductor Taylor said that when his engine made the movement south through track 4 the switches were left lined for a return movement along the same route but during the few minutes which elapsed between the two movements track 5 switch had been thrown for a movement along that track. He had instructed Trainman Cox concerning the movements to be made and as he was satisfied that the trainman, who was a man of long experience, understood what was

intended he was depending upon him to see that the switches were properly lined up. He assumed that Trainman Cox was riding the front or leading end of the caboose during the course of the back-up movement, as his duties required, and although it was evident from the position in which his body was found that he was actually riding on the footboard between the tender and the caboose the conductor was unaware of the fact. He said that there is a general order which prohibits riding on the leading footboard of the engine in a movement of this kind. Conductor Taylor had his back to the yard engine and from his position on the west side of the south platform of the caboose he could not see the position of track 5 switch. At the time of the accident it was misty and the rail was slippery but vision was good.

The statement of Trainman Johnson agreed with that of Conductor Taylor. He, too, failed to notice the position of the switch leading to track 5 and assumed that Trainman Cox was looking out for the switches and was riding the leading end of the caboose as his duties required.

Trainman Cavanaugh was on the footboard at the south end of the engine while the movement northward with the caboose was being made. He did not know the position of track 5 switch, and was depending upon Trainman Cox to have the switches properly lined.

Engineman Boyce said that Fireman O'Neil was acting in the capacity of engineman at the time of the accident and he, himself, was on the fireman's side of the cab. After coupling to the caboose he did not notice that track 5 switch was improperly lined until the engine had passed it. He called a warning of danger, but as they were then only about one car length from the cars on track 5 it was too late to avert the collision which occurred while they were moving at a speed of about 6 miles per hour. The accident occurred at about 2:07 p.m.

Fireman O'Neil who was running the engine could not see the switch indication from the engineman's side of the cab; when he heard the warning of danger he immediately applied the brake in emergency and reversed the engine, but as the rail was slippery the engine skidded.

Neither Engineman Boyce, Fireman O'Neil nor Trainman Cavanaugh saw Trainman Cox after the back-up movement was started, but they assumed that he was on the front or leading end of the caboose.

Flagman Grant, of Train AW-2, stated that he was called to go on duty at 2:30 p.m., and that he left the yard office to go to his train. On reaching a point about two car lengths from track 5 switch, yard engine 307 moving southward passed him. When he reached the switch involved he changed the route from the lead track to track 5 for the movement of his own train.

Discussion

On the trip from the north end of the yard, engine 307 moved through receiving track 4 and continued southward along the lead track to the caboose track. It was intended to make a return movement over the same route but shortly after engine 307 had passed by track 5 switch the flagman who had been called for Train AW-2, which was on track 5 awaiting the arrival of its engine, threw that switch for a movement into track 5, so that it would be properly lined for his own train. Yard engine 307 switched out caboose 8340 from the caboose track, and after coupling to it at a point about 334 feet south of track 5 switch, started the return movement to the north end of the yard. About 5 or 10 minutes had elapsed between the time track 5 switch was passed on the southward movement and the time the northward movement was started. During the trip northward Trainman Cavanaugh was on the footboard at the head or south end of the engine, while Conductor Taylor and Trainman Johnson rode on the south platform of the caboose. None of these men paid any attention to the position of Trainman Cox and as it was his duty to see that the switches were properly lined, they assumed that he was at the north or leading end of the caboose, although the investigation disclosed that Trainman Cox did not take his proper position but was riding on the footboard between the tender and the caboose in plain view and only a few feet away from Conductor Taylor. As no member of the crew noticed that the route had been set for track 5 the engine and caboose entered that track and before the error was discovered had reached a point so close to the cars standing on that track that a collision could not be avoided. Why Trainman Cox was not properly stationed on the front or north end of the caboose during the course of the back-up movement could not be determined as he was killed in the accident. The fireman was running the engine and was not in position to see the switch indication; had any of the other members of the train crew been on the alert and maintaining a proper lookout ahead they would have noticed that track 5 switch was improperly lined for the return movement and the accident would have been averted.

Conclusion

This accident was caused by failure of a switch crew to make sure that a yard switch was properly lined for an intended movement.

Respectfully submitted,

W. J. PATTERSON,

Director.