

INTERSTATE COMMERCE COMMISSION.

REPORT OF THE DIRECTOR OF THE BUREAU OF SAFETY IN RE INVESTIGATION OF AN ACCIDENT WHICH OCCURRED ON THE NEW YORK CENTRAL RAILROAD AT REMSEN, N. Y., ON JANUARY 3, 1931.

February 16, 1931.

To the Commission:

On January 3, 1931, there was a derailment of a passenger train on the New York Central Railroad at Remsen, N. Y., which resulted in the death of one employee, and the injury of five passengers and one employee.

Location and method of operation

This accident occurred on that part of the Adirondack Division extending between Utica and Malone, N. Y., a distance of 173 3/4 miles. In the vicinity of the point of accident this is a single-track line over which trains are operated by time-table, train orders, and a manual block-signal system. The accident occurred at a switch located 2,871 feet north of the station at Remsen, which leads off to the right from the main track to a track known as the long siding, approaching this switch from the north the track is tangent for a distance of 4,450 feet, followed by a curve of 0° 36' to the right, 938 feet in length, and then tangent track to the point of accident, 381 feet distant. The grade for north-bound trains is slightly descending for southbound trains, being 0.59 per cent descending for 680 feet preceding the point of derailment.

The switch involved in this accident is a facing-point switch for southbound trains. The switch stand is located on the left or fireman's side of a southbound train. It is of the low Rappo type, and is about 2 1/2 feet high. No metal target is used in connection with this switch, the position of the switch points being indicated by a 24-hour oil burning lamp, which displays a green indication when it is set for the main line and a red indication when the switch is set for the long siding.

It was snowing and stormy at the time of the accident, and because of the storm the view of the switch lamp was obscured until a train was within 300 feet of it; the color of the switch lamp indication, however, could not be distinguished for more than 150 feet distant. The accident occurred at 3 58 p.m.

Description.

Northbound local freight train UR1, hauled by engines 3183 and 3653, in charge of Conductor McConnell and Engineer Loftus and Cocoran, arrived at Rensen at about 11 a. m., completed its switching duties and left Rensen at about 12.20 p. m. without having restored the switch at the north end of the long siding for the main track. Northbound passenger train No. 3 left Rensen at 3.05 p. m., and ran through the switch, which was a trailing-point switch for that train, without the engineer knowing that it was set for the long siding, leaving the switch points in a partly open position.

Southbound passenger train No. 2 consisted of one baggage car, one mail car, one combination baggage and smoking car, two coaches, and one Pullman drawing-room car, in the order named, all of all-steel construction, hauled by engine 3077, and was in charge of Conductor Jencks and Engineer Kelly. At about 3.38 p. m., this train entered the switch leading to the long siding, at Rensen, and was derailed while traveling at a speed estimated to have been about 30 miles an hour.

The engine and first four cars entered the siding track at the switch and were derailed at a point 11 feet from the switch points; the engine came to rest on its right side at a point 397 feet south of the initial point of derailment. The following four cars also followed the rails of the side track and were derailed but remained upright on the roadbed. The employee killed was the engineer.

Summary of evidence.

Examination of the switch after the accident showed that it had been thrown and latched for the siding track. It was evident that it had been ^{run} through and the switch points split, both points being about 2 inches from the stock rails.

Conductor McConnell, of local freight train UR1, said he was standing near the caboose and noticed Brakeman Payne walking toward the switch at the main line and long siding just before the engines coupled to the train preparatory to leaving Rensen. He then went inside the caboose and did not again look in the direction of the long siding switch. He said it was his practice to see that switches are properly adjusted after being used by his brakemen out on this occasion he failed to observe the indication of the long siding switch and admitted his responsibility for the accident that followed.

Brakeman Payne said it was his duty and he was in position to reline the long siding switch for the main line after being used by the engines of his train and that it was his intention to do this, but as he was approaching the switch stand he heard air escaping from one of the cars of his train near-by and the engine air pumps were working unusually hard; he forgot about the switch and went to where the air hose has parted, made the coupling and adjusted the angle cock, and about that time remembered that he had some train orders for the engines. He went to the engines, delivered the orders and the train started immediately. He waited at that point for the daboose, boarded it as it passed and did not again think of the long siding switch. He acknowledged his responsibility for the accident which resulted from his neglect to reline the siding switch for the main line.

Engineman Albright, of northbound passenger train No. 3, said his train left Hensen at 3.05 p. m. and he was not aware that he had run through the long siding switch at Hensen until some time later when he learned of the accident. He said it was snowing and a strong west wind blowing at the time he left Hensen and he did not observe the indication of the switch light at the long siding.

Conductor Jencks, of train No. 3, said he examined the switch shortly after the accident and found the switch thrown and latched for the siding. He estimated the speed of his train at the time of the derailment to have been about 25 or 30 miles an hour.

Fireman Daly, of train No. 2, said he was sitting on the seat box approaching Hensen, looking ahead, and while there was a light rain falling at the time, which turned to sleet as it fell, it did not greatly affect his view of the track ahead. He said the engineman shut off steam about $\frac{1}{4}$ mile north of the switch and the train was drifting at a speed of about 25 miles an hour at the time of the derailment. He also said that on account of the low switch stand and small target arrangement of switches of the type involved in this accident, the indications of these signals are particularly difficult to see, and that he did not notice the indication of the switch light on account of the drifting snow, his first intimation of anything wrong being when he felt the engine bumping over the ties.

Conclusions.

This accident was caused by an improperly set switch, for which Conductor McConnell, of local freight train URI, is primarily responsible.

Rule 104, of the book of rules of the operating department, reads in part as follows:

"104 Switches must be left in proper position after having been used. Conductors are responsible for the position of switches used by them or their trainmen * * * *"

While the evidence plainly indicates Brake man Payne was negligent in failing to close and lock the long siding switch, under the rule above quoted, Conductor McConnell is responsible for this accident, it being his duty to know that this switch was properly set after having been used by his train. Brake man Payne is open to severe censure, however, for his negligence and failure properly to reline this switch. Engineer Albright, of northbound passenger train No. 3, is also open to censure for running through this switch.

Main line switches, particularly those on single-track lines should be so located and constructed that their indications can be seen a sufficient distance within which a train running at the maximum speed permitted may be stopped should the switch be set against it; or, if not so located should be provided with signals to indicate their position. It is evident from the testimony of the employees involved and from vision tests made subsequent to the accident, that there was not a sufficient view of the switch involved in this accident to enable a train approaching it at ordinary speed to stop before entering it, especially under the existing weather conditions in this instance.

Had an adequate automatic train control device, been in use on this line, this accident undoubtedly would have been prevented.

None of the employees involved in this accident had been on duty in violation of any of the provisions of the hours of service law.

Respectfully submitted,

W. P. BORLAND,

Director.