INTERSTATE COMMERCE COMMISSION

REPORT OF THE DIRECTOR OF THE BUREAU OF SAFETY IN RE INVESTIGATION OF AN ACCIDENT WHICH OCCURRED ON THE NORFOLK & WESTERN RAILWAY NEAR ROANOKE, VA., ON SEPTEMBER 10, 1923.

October 18, 1923.

To the Commission:

On September 10, 1923, there was a derailment of a freight train on the Norfolk & Western Railway near Roanoke, Va., resulting in the death of two employees, and the injury of five other persons and two employees.

Location and method of operation.

This accident occurred on that part of the Shenandoah Division extending between Shenandoah and Roanoke, Va., a distance of 132.6 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 about 3 miles north of Roanoke, approaching this point from the north there is a 30-minute curve to the right 850 feet in length, followed by 196 feet of tangent, the accident occurring on this tangent at a point 165 feet from its northern end; the grade is 1.5 per cent descending for southbound trains for about a mile north of the point of accident. The track in this vicinity is laid with 100-pound rails, 33 feet in length, with 20 to 21 white oak ties to the rail-length, tie-plated, and ballasted with crushed slag. The track is well maintained.

The switch at the point of accident is a facing-point switch for southbound trains, and leads gradually off the main track to the east, through a No. 10 turnout, to the Rockydale Stone Company spur. At the time of the accident there was a car of lumber and a car of coal standing on the siding. The switch stand, of the high Ramapo type, is located on the fireman's side of a southbound train; the red target has pointed ends, and the green target rounded ends The view approaching the point of accident is unobstructed. Southbound freight trains are not permitted to exceed a speed of 35 miles an hour. The weather was clear at the time of the accident, which occurred at about 10.30 a. m.

Description.

Southbound freight train first No. 51 consisted of 49 cars and a caboose, hauled by engines 1123 and 1114, and was in charge of Conductor Dean and Enginemen Creasy and Huddleston. This train passed Cloverdale, 7.1 miles north of Roa-

noke, at 10.23 a. m., 45 minutes late, and was derailed at the switch leading to the Rockydale Stone Company spur while traveling at a speed estimated to have been between 25 and 30 miles an hour.

Engine 1123 followed the main track and turned over to the left, coming to rest about 265 feet south of the switch. Engine 1114 entered the siding, struck and demolished the cars standing on it, and came to rest to the left of the siding, in an upright position. The first 6 cars and the 12th to the 23rd cars, inclusive, were derailed. The employees killed were the engineman and fireman of engine 1123.

Summary of evidence.

Section Foreman Lucas and Track Walker Gibson said they had changed a king pin on the switch, that Track Walker Gibson operated the switch several times and that it was then closed and locked. According to the train sheet, southbound passenger train No. 1 and southbound freight train extra 1386 passed this point at about 9.20 a. m. and 9.35 a. m., respectively, and the section foreman and track walker said the work at the switch was done between the times of these two trains, and that they then proceeded to a point approximately 100 yards north of the switch where work was being done on the track, and were at that point when the accident occurred. On the other hand, G. W. Lynn, employed by the stone company, was unloading one of the cars on the siding at the time of the accident and he said it was about 10 minutes before the occurrence of the accident, or about 10.20 a. m., when he saw two men working at the switch.

When train first No. 51 came to a stop after the accident, the forward truck of the eighth car was south of the switch points and the rear truck north of the points, which could be opened and closed without difficulty. Examination made of the switch shortly after the accident by various persons showed that it had been closed and locked. Both the section foreman and the track walker denied having touched the switch after the accident, and Track Walker Gibson said that on account of his nervous and excited condition he did not immediately go to the head end of the derailed train, but finally went ahead, accompanied by the section foreman and stopped near the switch while the section foreman went on. Track Walker Gibson said he did not notice the position of the switch at this time but after finally reaching the head end of the train, assisting in getting out the injured and then going back to the switch, he found it to be closed and locked Section Foreman Lucas said he was so frightened that he remained in a nearby field for about half an hour, then saw Engineman Huddleston at the switch and proceeded to that point. He inquired as to the cause of the accident and was told by Engineman Huddleston that he thought it was a split switch. Although

Engineman Huddleston knew Section Foreman Lucas and remembered having seen him at the accident, he did not remember having seen him at the switch or telling the section foreman what he thought caused the accident. Statements of the various track laborers developed nothing of importance except that all of them said the section foreman and track walker were at the switch prior to the time of the passage of extra 1386.

Engineman Huddleston, in charge of engine 1114, said he first noticed the jumping of the tender of engine 1123 and he thought that engine entered the siding. He estimated the speed to have been about 30 miles an hour, which estimate was practically corroborated by that of his fireman. The fireman examined the switch about 10 minutes afterwards and the engineman about 25 minutes afterwards, both of them finding it closed and locked, with the switch points fitting properly.

The construction foreman of the stone company said he heard a whistle and on looking around saw the first engine proceeding on the main track and the other moving on the siding, and he said he met the section foreman at the frog of the switch, about 10 minutes afterwards, walking toward the head end of the train, and that he himself continued back to the switch and found it closed and locked.

The track at the switch was not damaged and the marks on the rails and ties indicated that only one pair of wheels was derailed. The wheel marks on the ties were to the right of and close to the side track rails, those to the right of the right rail commencing 20 feet beyond the switch point, and those to the right of the left rail commencing 12 feet 6 inches beyond the switch point. The track was not torn up until a point south of the frog was reached. Careful inspection of the track showed it to be in good condition, while nothing was discovered in connection with either engine which could have contributed to the occurrence of this accident

Conclusions.

This accident was caused by a switch not being properly closed and locked, for which Section Foreman Lucas is primarily responsible.

The manner in which the equipment came to rest, with the lead engine having proceeded on the main track and the balance of the train on the siding, shows that the switch could not have been properly closed and locked, and indicates that the movement of the lead engine over the switch points caused them to open under the train and result in its derailment. The train stopped with the rear truck of the eighth car north of the switch points and the forward truck south of the points, leaving the switch so it could

be operated without difficulty, and when it was examined very shortly after the accident it was found closed and locked. While it is obvious it could not have been in this position at the time of the accident, yet the investigation did not develop by whom this switch was closed. It is believed, however, that the section foreman and track walker, after completing their work at the switch prior to the accident, and operating the switch to see that it worked properly, failed to close and lock it, for which Section Foreman Lucas, being accountable for the position of switches used by him or his men, is responsible.

All the employees involved were experienced men, and at the time of the accident none of them had been on duty in violation of any of the provisions of the hours-of-service law.

Respectfully submitted,

W. P. BORLAND,

Director.