REPORT OF THE DIRECTOR OF THE BUREAU OF SAFETY IN RE INVESTIGATION OF AN ACCIDENT WHICH OCCURRED ON THE LINE OF THE OGDEN UNION RAILWAY AND DEPOT COMPANY AT OGDEN, UTAH, ON NOVEMBER 1, 1928

January 7, 1929

To the Commission.

On November 1, 1928, there was a head-end collision between two transfer movements on the tracks of the Ogden Union Railway & Depot Company at Ogden, Utah, which resulted in the death of one employee and the injury of one employee. This accident was investigated in conjunction with a representative of the Public Utilities Commission of Utah.

Location and Method of Operation

This is a terminal company using neither time-table nor train orders, all operation being confined to yard movements under the operating rules of the Union Pacific Railroad. The accident occurred on what is known as the stock yards lead track, which is a portion of the principal route between the two ends of the yard. Approaching the point of accident from either direction the track is a series of short curves and tangents, the accident occurred not far from the center of a section of tangent track 710 feet in length where the grade is 0.25 per cent descending for westbound trains

A light rain was falling at the time of the accident, which occurred at 1 35 a.m.

Description

The eastbound transfer consisted of 12 cars being pushed ahead of engine 4413, which was headed east, and was in charge of Foreman Brown and Engineman Sparks. It proceeded eastward on No 6 lead track until it reached what are called the twin switches. After stopping at this point for the purpose of throwing a switch the transfer entered on the stock yards lead track and had proceeded on that track a distance of about 400 feet, moving at a speed of 4 or 5 miles per hour, when it collided with a transfer handled by engine 340.

The westbound transfer consisted of nine cars pushed ahead of engine 240, which was headed east, and was in charge of Foreman Hull and Engineman Fife. This movement was en route westward via the stock yards and No. 6 lead tracks to the Denver & Rio Grande Western interchange track, about 1,500 feet west of the twin switches, when it collided with transfer 4413 while traveling at a speed of 4 or 5 miles per hour.

The rear end of the fourth car in transfer train 240 telescoped the car following it, these two cars then falling against and overturning a car which was standing on an adjoining track. Fire broke out in the wreckage and caused considerable damage. The employee killed was the foreman of transfer 240.

Summary of Evidence

Switchman Tanner, of transfer 240, said he was riding on top of the leading car at the time of the accident, looking in the direction in which the transfer was moving, but at no time did he observe any lighted lanterns of the members of the crew of the opposing transfer until just prior to the accident. The first knowledge he had of anything wrong was on seeing the leading car of the opposing transfer, about one car-length distant, he immediately shouted a warning of danger and gave stop signals with his lighted lantern, and he said that at this time two lighted lanterns came into view on top of the leading car of transfer 4413. Switchman Tanner stated that Foreman Hull and Switchman Billings, of his own crew, were riding on top of a car about four cars back from the leading car and that he could plainly see their lighted lanterns. Switchman Marion was riding on the car ahead of the engine, his testimony corroborated in substance that of Switchman Tanner. Engineman Fife and Fireman Williamson saw the stop signals given by Switchman Tanner just prior to the collision and said that these signals also were passed along by Foreman Hull and Switchman Billings. No statements were obtained from Switchman Billings, who was seriously injured.

Foreman Brown and Switchman Johnson, of transfer 4413 said they were riding on top of the leading car at the time of the accident. Neither of them observed any lighted lanterns of members of the crew of the opposing transfer until just prior to the accident, at which time Foreman Brown gave

stop signals. Switchman Hirsinson, who rode on top of the car ahead of the engine, said he could see the lighted lanterns of Foreman Brown and Switchman Johnson on the leading car. Engineman Sparks stated that he could see the lighted lanterns of the three members of his crew, upon receiving the stop signals he immediately applied the air brakes in emergency, opened the sanders and had moved the reverse lever about half-way over when the collision occurred. Fireman Shore gave testimony similar to other members of each crew in regard to visibility, speed, etc., although on account of the curvature of the track he was not in position to observe just what actually transpired immediately prior to the collision.

Night Assistant Yardmaster Turner stated that he was in the immediate vicinity of the point of accident when it occurred, just prior to which time transfer 240 had passed his office; he observed the forward portion of the transfer at that time and said he saw a man riding on the side of the leading car, but that he saw no one riding on top of that car.

Conclusions

This accident was caused by the failure of Foreman Brown and Switchman Johnson, of transfer 4413, and of Switchman Tanner, of transfer 240, to maintain a proper lookout and definitely know that the way was clear for the movements being made by their respective transfers.

In addition to a very heavy yard movement daily in both directions over this route there are numerous engine movements as well as main line freight train movements, all of which call for a sharp lookout being maintained at all times on the part of yard crews. The testimony was to the effect that while it was drizzling and dark yet lighted hand lanterns could be seen plainly, and had a proper lookout been maintained by any one of the three employees who were riding on the tops of the leading cars in their respective transfers, there is no reason why the opposing transfers should not have been seen in ample time to have averted the accident. With respect to Switchmen Tanner and Johnson it appeared that neither of them had had over 11 weeks' experience, while Foreman Brown had not had proper rest during his off-duty period.

The investigation developed that it is the practice when making movements similar to the one being made by transfer 4413 to shove cars ahead of the engine for a distance of practically three-fourths of a mile and then to make a drop of the cars toward what is known as the Globe Mills track and across the Oregon Short Line Railroad freight main track. Opportunity is afforded at the west end of the yard to run around these cars, thereby enabling engines to haul transfers instead of shoving them, and had transfer 4413 been so handled on this occasion, the danger of shoving cars on this busy track, subsequently dropping them across the Oregon Short Line freight main, would be eliminated.

At the time of the accident none of the employees involved had been on duty in violation of any of the provisions of the hours of service law.

Respectfully submitted,

W. P. BORLAND,

Director.