

INTERSTATE COMMERCE COMMISSION

REPORT OF THE DIRECTOR OF THE BUREAU OF SAFETY IN RE
INVESTIGATION OF AN ACCIDENT WHICH OCCURRED ON THE
TEXAS & NEW ORLEANS RAILROAD, SOUTHERN PACIFIC LINES,
NEAR POYNOR, TEX., ON JANUARY 4, 1924.

February 10, 1924.

To the Commission:

On January 4, 1924, there was a derailment of a passenger train on the Texas & New Orleans Railroad, Southern Pacific Lines, near Poynor, Tex., resulting in the death of one employee, and the injury of six passengers, one person carried under contract, and one employee.

Location and Method of operation.

This accident occurred on the Dallas-Jacksonville Sub-Division of the Beaumont-Galveston Division, extending between Jacksonville and Ft. Worth, Tex., a distance of 131.4 miles; in the vicinity of the point of accident this is a single-track line over which trains are operated by time-table and train orders, no block signal system being in use. The derailment occurred at a point about 2.9 miles east of Poynor, at a switch which leads off the main track through a No. 9 turnout to the north to a stub-end siding 394 feet in length, known as the Eastwood spur; this is a facing-point switch for eastbound trains. Approaching the point of accident from the west there is a 3° curve to the right, 1,269 feet in length, followed by 1,475 feet of tangent, the accident occurred on this tangent at a point near its eastern end. The grade is slightly descending for eastbound trains. The switch-stand is located on the fireman's side of an eastbound train, a red disk, 18 inches in diameter, is displayed when the switch is lined for the spur, but this disk is not visible when the switch is lined for the main track, this being its normal position. An unobstructed view can be had of the switch target for more than 1,700 feet. The weather was clear at the time of the accident, which occurred at about 11.58 a.m.

Description.

Eastbound passenger train No. 156 consisted of one baggage and mail car, and three coaches, in the order named, of all-steel construction, hauled by engine 325, and was in charge of Conductor Green and Engineman Alder.

This train left La Rue, 5.9 miles from Poynor, at 11.41 a.m., 50 minutes late, and was derailed at the switch leading to the Eastwood spur while traveling at a speed estimated to have been between 25 and 35 miles an hour.

Engine 235 and the forward truck of the first car ran off the end of the spur, the engine remained upright but was considerably damaged. The employee killed was the engineman.

Summary of evidence.

At Athens, 19.11 miles from Poynor, train No. 156 received a train order to run fifty minutes late from La Rue to Jacksonville. Fireman Fagan stated that approaching Eastwood spur the speed was about 25 or 30 miles an hour, and both he and Engineman Aldis were sitting on their seat boxes. Although the view of the switch-target is unobstructed, and its indication plainly showed that the switch was open, Fireman Fagan said he did not ascertain definitely that it was lined for the spur until he was about 75 feet from it. Just as he turned to shout, Engineman Aldis closed the throttle and applied the air brakes in emergency, at which time the engine was about 15 feet from the switch. Fireman Fagan further stated that there was nothing about the condition of the engine to distract attention from keeping a proper lookout ahead, nor did he notice any one in the vicinity of the switch. Conductor Green stated that he felt the air brakes applied in emergency just prior to the accident. Immediately after the accident the switch was found to be lined for the spur, the lever in the socket and latched, but the lock was missing.

Eastbound extra 258 passed over the switch involved less than forty-five minutes prior to the accident, and at that time none of the members of that crew noticed anything unusual in this vicinity.

A boy, aged 14, was seen in the vicinity of the switch a short time prior to the accident. Upon being questioned, he admitted he had broken the switch lock, lined the switch for the spur and hid the lock. This boy was taken into custody by the local authorities.

The air brakes on train No. 156 had been tested and worked properly en route.

Conclusions.

This accident was caused by an open switch, due to mischievous tampering.

Although the switch was lined for the spur, the switch-target was brightly painted and plainly visible from the cab of an eastbound engine for more than 1,700 feet, Engineman Aldis and Fireman Fagan were sitting on their seat boxes approaching the switch, and there was nothing about the condition of the engine to distract their attention, they did not notice that the switch was open until it was too late to avert the accident. Had they been keeping a proper lookout ahead, or had an automatic train control system been in use on this line, this accident might have been prevented.

All of the employees involved were experienced men. At the time of the accident they had been on duty less than 5 hours, prior to which they had been off duty for periods ranging from 10 $\frac{1}{2}$ to 33 hours.

Respectfully submitted,

W. P. BORLAND,

Director.