SUMMARY FOR FE-23-03
SELECTED AND POSSIBLE CONTRIBUTING FACTORS

SELECTED FACTORS

Railroad: Union Pacific Railroad Company
Location: Ogden, Utah
Region: 7

Month: September
Date: Sept. 14, 2003
Time: 1:15 p.m., MST

Data for Fatally Injured Employee(s)

Conductor
53 years old
26 years of service
Last rules training: May 24, 2001
Last safety training: Sept. 14, 2003
Last physical: June 26, 2003

Data for All Employees (Craft, Position, Activity)

Craft: Transportation and Engine

Positions:

Yard Switch Job, YOG17
Engineer
Conductor
Two Switchmen

Activity: Switching

EVENT

A Conductor was riding the end of a free-rolling, 2-car cut, whose speed he was controlling with a handbrake, when he fell, and the cars ran over him, amputating his legs. Still alive at the scene, the Conductor was airlifted to the hospital, where he was pronounced dead.

SUMMARY FOR FE-23-03 CONTINUED

POSSIBLE CONTRIBUTING FACTORS

PCF No. 1

Investigators concluded that the Conductor either stepped on the uncoupling lever and/or bracket (which was defective with poor weld penetration and a missing support brace) or fell on them just before falling from the car.

PCF No. 2

The Conductor did not place himself in a safe position to ride the cut of cars (including firm footing and hand hold to prevent slipping, falling, or injuries), in non-compliance with the railroad's operating rules.

REPORT: **FE-23-2003**

RAILROAD: Union Pacific Railroad Company (UP)

LOCATION: Ogden, Utah

DATE & TIME: Sept. 14, 2003, 1:15 p.m., MST

EVENT[1]: The Conductor was riding the end of a free-rolling, 2-car cut, whose speed he was controlling with a handbrake, when he fell, and the cars ran over him, amputating his legs. Still alive at the scene, the Conductor was airlifted to the hospital, where he was pronounced dead.

EMPLOYEE:

Craft:	Transportation and Engine (T&E)
Activity:	Switching
Occupation:	Conductor
Age:	53 Years
Length of Service:	26 Years
Last Rules Training:	May 24, 2001
Last Safety Training:	Sept. 14, 2003
Last Physical:	June 26, 2003

CIRCUMSTANCES PRIOR TO THE ACCIDENT

After receiving their statutory off-duty period, a local yard switch crew comprising a Conductor, two Switchmen, and an Engineer reported for duty at 7 a.m., MST, on Sept. 14, 2003, at Riverdale Yard in Ogden, Utah. The crew was called to work Yard Switch Job, YOG17, performing switching service at the south end of the Riverdale Yard.

The crew's assignment was to place cars on various yard tracks that branched off of the south lead track. First, the crew members proceeded northward on the south lead and decided to place two cars onto Track No. 21. They stopped near the Track No. 15 switch to uncouple the two cars and allow them to roll freely onto Track No. 21. One Switchman subsequently uncoupled the cars, and the Conductor boarded the northeast corner of Freight Car CNW 137337 to control the speed of the cars by operating the hand brake. The loaded cars began rolling slowly down the south lead track toward Track No. 21, which has a descending grade of 0.41 percent.

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[1] "Event" is defined as "occurrence that immediately precedes and directly results in the fatality." Possible contributing factors are identified in the following report and attached summary.

At the time of the accident, the Engineer was seated at the locomotive's controls and one Switchman was on the ground at the southwest corner of the second car, uncoupling the cars. The Conductor was at the northeast corner of Freight Car CNW 137337, which was being switched onto Track No. 21.

Another Switchman working on this assignment had just ridden some cars onto another track to set the hand brakes. He was walking back up the lead from Track No. 15 and saw the Conductor riding on one of the cars headed for Track No. 21. He crossed over to the west side of the rail behind the cars and did not see the Conductor set the hand brake or fall.

THE ACCIDENT

As the two cars moved slowly over the lead track at about 3 mph, in the vicinity of the Track No. 18 switch, the Conductor, who was riding on Freight Car CNW 137337, fell and landed on the east rail. The cars rolled over and amputated both of his legs, then continued the movement and coupled to the cars on Track No. 21. After the accident, the injured Conductor was heard yelling by other employees, who rushed to his aid. They contacted emergency response personnel and attempted to stop the bleeding. The injured Conductor was subsequently air lifted to the hospital where he was pronounced dead.

POST-ACCIDENT INVESTIGATION

It is unknown whether the Conductor had stepped on the ladder or the uncoupling lever of Freight Car CNW 137337 to control the movement with the hand brake. It appears he either stepped on the uncoupling lever and/or bracket or fell on them just before falling from the car. The uncoupling lever bracket on the corner of the car was found to be broken at the butt weld where the bracket was attached to the car. The weld had poor penetration and was approximately 90 percent new break. The support brace that should have been underneath the uncoupling lever bracket was missing. The uncoupling lever and bracket fell off of the car and landed on the east rail and wedged against the wheel on the northeast corner of the car.

The hand brake on the lead car was found to be applied.

The uncoupling lever showed signs of falling to the ground approximately nine feet north of the Track No. 19 switch. The first signs of blood were approximately two feet north of the Track No. 19 switch, and the injured Conductor was found approximately 16 feet further south. There were indications of blood on all four wheels of Freight Car CNW 137337, and there was blood on the first wheel of the second car.

An autopsy, performed by the Office of the Medical Examiner for the State of Utah, determined the immediate cause of death was traumatic amputation of the lower extremities.

It was determined from interviews UP conducted with two of the surviving crew members that several job briefings had been held throughout the shift with all of the employees, prior to the accident.

A Federal post-accident toxicological test was performed by Northwest Technology, Inc. All test results were negative.

The Riverdale Police Department and Life Flight Medical Services responded to the accident.

APPLICABLE RULES

Union Pacific Railroad Company Employee Safety Rules, Effective Oct. 25, 1998

81.7.1 Designated riding places
When required to ride on cars, engines, or other equipment:
Ride on designated steps, ladders, or platforms.

81.11 Handbrake
When operating hand brake, inspect for defects. Use good body mechanics. Have firm footing and hand hold to prevent slipping, falling, or injuries (e.g., sprains, strains).

End mounted brake on equipment equipped with a brake step or platform and locomotive hand brake must be applied or released from a position on the equipment. When climbing on equipment, maintain at least a 3-point contact. This consists of both feet and one hand or both hands and one foot touching the equipment. When in position to apply or release an end-mounted brake with a platform, place your left foot on the ladder rung and your right foot on the brake platform. Grasp a ladder rung or the top hand hold with your left hand and operate the brake with your right hand. Do not place both hands on the brake wheel.

General Code of Operating Rules, Fourth Edition, Effective April 2, 2000

1.1.1 Maintaining a Safe Course
In case of doubt or uncertainty, take the safe course.

1.1.2 Alert and Attentive
Employees must be careful to prevent injuring themselves or others. They must be alert and attentive when performing their duties and plan their work to avoid injury.