



Fatal Incident Involving an In-Plant Railroad Conductor

A USW member was fatally injured when he was caught in-between the railcar he was riding and a stationary railcar on the adjacent track on the night shift with snow squalls and poor lighting in the area. The conductor was riding on the stirrup/ladder assembly on the northwest side of the front gondola car of a train being pushed to a car storage area. The conductor, following the Safe Operating Procedure that required rail personnel to not ride on the south side of the car to avoid the “pinch point” of the scale house. For that reason, he was riding on the northwest side of the moving car (opposite from the scale house). Unbeknownst to him and the locomotive engineer, a supervisor had directed the previous shift to park a train of gondola cars on a set of adjacent tracks to the north to save time. That train was made up of non-standard size cars (wider than usual) and was parked in the “foul” (area within four feet of the nearest rail of a railroad track) as directed and stated by the supervisor to his crew. This information was not communicated to the on-coming crew. Non-standard cars have not been stored on the adjacent track in the past due to their wider size, but the supervisor thought they would be able to get ahead of production by doing this.

As the train was in motion, the clearance between the moving train and the stationary railcars narrowed and the conductor was caught in-between the pinch-point between the cars of the two different trains. When the front car of the moving train passed the scale house, the locomotive engineer saw what he believed was a stop signal from the conductor. The engineer stopped the train, dismounted the engine. Eventually he and the shift supervisor found the fatally injured conductor pinned between the railcars.

The conductor commonly rides the front side ladder of the railcar to ensure the rails are free of obstructions. The crew had ridden through this area before with railcars in the area, but not with non-standard cars on the adjacent track. The crew had also been downsized and was now operating as a two person crew instead of three.



Recommendations to Prevent Recurrence:

- Eliminate pinch-point areas by applying the Hierarchy of Controls and spacing the tracks further apart.
- Form a labor-management railroad safety sub-committee to evaluate rail yard lighting, potential and permanent pinch-point areas and develop recommendations for improvements/corrections.
- Evaluate rail maps and yards for fixed and/or mobile foul/pinch points. Install safety markers and signs in safe locations.
- Utilize a Management Of Change and Management Of Organizational Change program for process and organizational changes that involves employees and their representatives. Include changes such as downsizing. If the proposed change is not safe, the change must not be made.
- Improve communication methods between shifts, conductors and locomotive engineers.
- Employee training, retraining and evaluations must include job transfers, even if the worker had previously held the job classification.
- Provide all hourly and salary employees with a Right-To-Act process and annual retraining. All hourly and salary employees must have a procedure and process to report hazards, stop unsafe/unhealthy jobs/tasks and shutdown any process without the fear of retaliation.



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This hazard alert is based on an actual incident, and reflects our best understanding of the incident at the time it was written. However, many incidents have multiple causes; this alert may not cover all of them. The purpose of the alert is to illustrate workplace hazards; it is not intended to be a comprehensive report on the incident.