Note that 49 U.S.C. § 20903 provides that no part of an accident or incident report, including this one, issued by the Secretary of Transportation and/or the Federal Railroad Administration under 49 U.S.C. § 20902 may be used in a civil action for damages resulting from a matter mentioned in the report.

Federal Railroad Administration, Office of Railroad Safety

Accident Investigation Summary Report FE-2023-16

CSX Transportation (CSX) – Mechanical Employee Fatality
Walbridge, Ohio
September 17, 2023

1. EXECUTIVE SUMMARY

On September 16, 2023, two CSX Transportation (CSX) mechanical department employees were assigned to perform a Class I airbrake test on cars located in CSX's Walbridge East Bound Yard in Walbridge, Ohio. The employees, who regularly worked together, were operating within an active remote-control zone (RCZ) controlled by a remote-control operator (RCO) managing yard remote locomotive Y397 (Train 1). After confirming with the RCO that Train 1 had completed work on Tracks E03 and E05, the two mechanical employees proceeded to secure and lock the track switches, in preparation for conducting the airbrake testing.

The employees used a company truck to access various locations within the yard. During this time, Train 1, consisting of lead engine CSX 2032 and trailing engine CSX 8033, was making a light power move in a southbound direction on the East Bound Switching Lead. Security footage later showed one of the employees parking the truck next to the active track, exiting the vehicle, and beginning to walk west across the yard lead to lock the switch for Track E05. At approximately 3:24 a.m., EDT, on September 17, 2023, the employee was fatally struck by Train 1 as it moved in a southbound direction as he crossed the yard lead.

Despite adequate overhead lighting and the locomotive's headlight being operational, the decedent failed to observe the oncoming train before stepping onto the track. The exact cause of this oversight remains unknown. The weather conditions at the time were clear, with a temperature of 63°F and no precipitation.

2. ACCIDENT DESCRIPTION

On September 16, 2023, two CSX employees, including the decedent, reported for duty at 11 p.m., EDT, at the Walbridge East Bound Yard in Walbridge, Ohio. A job briefing was received from their supervisor and their assignment was to perform a Class I airbrake test on railcars situated on Tracks E03 and E05. The switches to these tracks were within an RCZ managed by an RCO operating yard remote locomotive Y397, known as Train 1: however, the body of the tracks are not withing the RCZ. The employees confirmed with the RCO via radio that Train 1

had completed its work on these tracks before proceeding with their task. Permission from the Train 1 RCO was not required to apply Blue Signal protection on the tracks.

The two employees used a company truck to navigate the yard, driving along a service road to access and secure switches necessary for the airbrake test. During this time, Train 1, led by engine CSX 2032 with a trailing engine CSX 8033, was making a light power move southbound on the East Bound Switching Lead. Security camera footage later showed the decedent parking the truck near the active yard lead track and exiting the vehicle. Without stopping to check for any train movement, the decedent began walking across the East Bound Switching Lead towards the switch for Track E05. At approximately 3:24 a.m., EDT, on September 17, 2023, the decedent was struck and fatally injured by Train 1 as it moved southbound along the yard lead.

3. INVESTIGATION AND ANALYSIS

Track Analysis

The Federal Railroad Administration (FRA) thoroughly inspected the track conditions at the site of the accident, focusing on the Midwest Division, Toledo Terminal Subdivision—specifically in Walbridge Yard at Milepost (MP) CDA115.5. The track structure was found to be in good condition, constructed with 9-inch by 7-inch standard timber crossties spaced on 23-inch centers, and secured with 132-pound RE vacuum-treated jointed rail. The track in the area of the accident was tangent, with a maximum speed limit of 10 mph. All track geometry measurements were within FRA Track Safety Standards and CSX engineering design standards. The walking conditions, including the shoulder ballast and crosstie cribs, were found to be filled, level, and free of debris. FRA concluded that the track conditions did not contribute to the cause or severity of the accident.

Employee Training, Experience, and Qualifications Analysis

The decedent had 19 years of experience and had passed his Mechanical Operating Rules and Blue Signal Protection exam on February 6, 2023. Similarly, the other mechanical employee, also with 19 years of experience, had passed the same exam on January 30, 2023. The RCO involved had 10 years of experience and was qualified on the territory, having passed his most recent Transportation Operating Rules exam and Locomotive Engineer and Conductor Annual Training on February 12, 2022. The RCO also passed the Remote-Control Operator – Recertification exam on September 8, 2023. All three employees were current on their training and demonstrated compliance with safety rules through periodic efficiency testing. FRA concluded that the employees' training, experience, and qualifications did not contribute to the accident.

Operating Practice Analysis

FRA reviewed radio recordings and witness statements to reconstruct the sequence of events. At 3:17:16 a.m., the mechanical employees requested confirmation over the radio from Train 1's RCO that Tracks E03 and E05 were clear for them to lock out. The RCO responded affirmatively at 3:17:44 a.m., but this message was not received by the employees on their handheld radio. The employees then contacted the Yardmaster, who relayed the RCO's confirmation at 3:18:17 a.m. No explicit permission was needed from the RCO to lock out the switches, and the radio exchange served as confirmation that Train 1 was no longer working on these tracks.

Shortly before the accident, the decedent and the other mechanical employee drove north along the service road and parked near the switch for Track E05 and adjacent to the active yard lead track. Surveillance footage reviewed by the National Transportation Safety Board (NTSB) and FRA investigators showed the decedent exiting the truck and walking across the active yard lead toward the switch without stopping to check for oncoming traffic. This was a violation of CSX Operating Manual Rule 2100.4, which requires employees to stop and look in both directions before crossing or fouling a track. The decedent's failure to adhere to this rule placed him directly in the path of the oncoming locomotives, resulting in the fatal accident. The other mechanical employee, unaware of the accident, exited the truck to place a blue signal on Track E05. Upon returning, he discovered the decedent lying near the track and immediately called for all train movement in the yard to cease.

Equipment Analysis
The locomotives involved in the accident, CSX 2032 and CSX 8033, were inspected by an FRA Motive Power & Equipment Inspector on September 17, 2023. CSX 2032, a lead remote-control locomotive (RCL) built in 1972 and rebuilt to a GP38-3 model, and CSX 8033, a trailing EMD SD40-2 model built in 1979, were both found to be in proper working order. The inspection confirmed that all operational systems, including headlights, ditch lights, bell, horn, and RCL beacon lights, were functioning correctly. No defects were found during post-accident inspections, leading to the conclusion that the equipment involved did not contribute to the accident.

Fatigue Analysis
FRA used the FAID Quantum (Fatigue Assessment Tool by InterDynamics) to analyze the decedent's work schedule for the 10 days preceding the accident. The analysis revealed that the decedent's FAID score did not exceed 63 (maximum 48), and the Karolinska Sleepiness Scale (KSS) score did not exceed 7 (maximum 6.9), indicating that fatigue was not a likely contributor to the accident. FRA concluded that the decedent was not exposed to significant fatigue risks at the time of the incident.

Drug and Alcohol Analysis
Post-accident toxicological testing, conducted in accordance with Title 49 of the Code of Federal Regulations (CFR), Part 219, returned negative results for the decedent. FRA determined that drug and alcohol use did not contribute to the cause or severity of the accident.

4. CONCLUSION

FRA's investigation into the accident that occurred on September 17, 2023, at CSX's Walbridge East Bound Yard in Walbridge, Ohio, has determined that the primary cause of the incident was the decedent's failure to adhere to CSX Operating Manual Rule 2100.4, which requires employees to stop and look in both directions before crossing or fouling a track.