



***Federal Railroad Administration  
Office of Safety  
Headquarters Assigned  
Accident Investigation Report  
HQ-2005-98***

***CSX Transportation (CSX)  
Oneida, New York  
November 1, 2005***

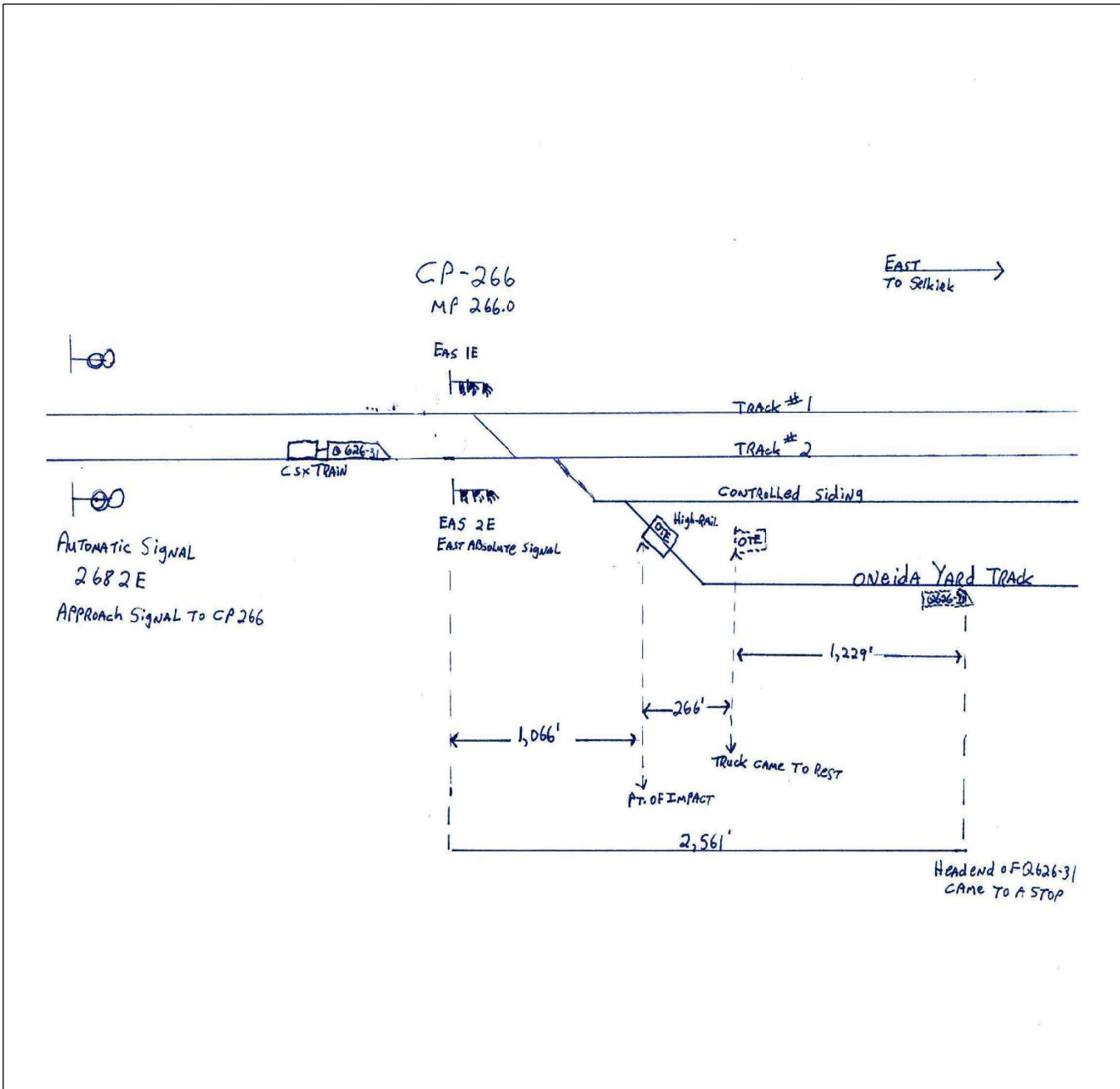
***Note that 49 U.S.C. §20903 provides that no part of an accident or incident report made by the Secretary of Transportation/Federal Railroad Administration under 49 U.S.C. §20902 may be used in a civil action for damages resulting from a matter mentioned in the report.***

1. Name of Railroad Operating Train #1 CSX Transportation [CSX]		1a. Alphabetic Code CSX		1b. Railroad Accident/Incident No. 000016265		
2. Name of Railroad Operating Train #2 CSX Transportation [CSX]		2a. Alphabetic Code CSX		2b. Railroad Accident/Incident 000016265		
3. Name of Railroad Responsible for Track Maintenance: CSX Transportation Intermodal [CSXT]		3a. Alphabetic Code CSXT		3b. Railroad Accident/Incident No. 000016265		
4. U.S. DOT_AAR Grade Crossing Identification Number		5. Date of Accident/Incident Month Day Year 11 01 2005		6. Time of Accident/Incident 02:44: <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		
7. Type of Accident/Incident (single entry in code box) 1. Derailment      4. Side collision      7. Hwy-rail crossing      10. Explosion-detonation      13. Other 2. Head on collision      5. Raking collision      8. RR grade crossing      11. Fire/violent rupture      (describe in narrative) 3. Rear end collision      6. Broken Train collision      9. Obstruction      12. Other impacts      09						
8. Cars Carrying HAZMAT 12	9. HAZMAT Cars Damaged/Derailed N/A	10. Cars Releasing HAZMAT N/A	11. People Evacuated 0	12. Division Mohawk		
13. Nearest City/Town Albany		14. Milepost (to nearest tenth) 0266.0	15. State Abbr Code N/A NY	16. County MADISON		
17. Temperature (F) (specify if minus) 68 F	18. Visibility (single entry) Code 1. Dawn 3. Dusk 2. Day 4. Dark 2	19. Weather (single entry) Code 1. Clear 3. Rain 5. Sleet 2. Cloudy 4. Fog 6. Snow 3	20. Type of Track Code 1. Main 3. Siding 2. Yard 4. Industry 2			
21. Track Name/Number Oneida Yard Lead		22. FRA Track Code Class (1-9, X) 1	23. Annual Track Density (gross tons in millions) N/A	24. Time Table Direction Code 1. North 3. East 3		
<b>OPERATING TRAIN #1</b>						
25. Type of Equipment Consist (single entry) 1. Freight train      4. Work train      7. Yard/switching 2. Passenger train      5. Single car      8. Light loco(s). 3. Commuter train      6. Cut of cars      9. Maint./inspect.car		A. Spec. MoW Equip. Code 1	26. Was Equipment Attended? 1. Yes 2. No 1		27. Train Number/Symbol Q62631	
28. Speed (recorded speed, if available) Code R - Recorded E - Estimated      47      MPH      R		30. Method(s) of Operation (enter code(s) that apply) a. ATCS      g. Automatic block      m. Special instructions b. Auto train control      h. Current of traffic      n. Other than main track c. Auto train stop      i. Time table/train orders      o. Positive train control d. Cab      j. Track warrant control      p. Other (Specify in narrative) Code(s) e. Traffic      k. Direct traffic control f. Interlocking      l. Yard limits			30a. Remotely Controlled Locomotive? 0 = Not a remotely controlled 1 = Remote control portable 2 = Remote control tower 3 = Remote control transmitter - more than one remote control transmitter 0	
29. Trailing Tons (gross tonnage, excluding power units) 7,575		n	N/A	N/A	N/A	
31. Principal Car/Unit (1) First involved (derailed, struck, etc) N/A		a. Initial and Number 1	b. Position in Train 1	c. Loaded (yes/no) yes	32. If railroad employee(s) tested for drug/alcohol use, enter the number that were positive in the appropriate box. Alcohol      Drugs 0      0	
(2) Causing (if mechanical cause reported) 0		0	N/A	33. Was this consist transporting passengers? (Y/N) N		
34. Locomotive Units		a. Head End	b. Mid Train Manual	c. Rear End Remote	35. Cars	
(1) Total in Train		2	0	0	(1) Total in Equipment Consist	
(2) Total Derailed		0	0	0	(2) Total Derailed	
36. Equipment Damage This Consist		100	37. Track, Signal, Way, & Structure Damage 0		38. Primary Cause Code H221	
39. Contributing Cause Code N/A		Number of Crew Members		Length of Time on Duty		
40. Engineer/Operators 1	41. Firemen 0	42. Conductors 1	43. Brakemen 0	44. Engineer/Operator Hrs 4 Mi 14		
45. Conductor Hrs 4 Mi 14		Casualties to:		49. EOT Device? 1. Yes 2. No 1		
46. Railroad Employees 0		47. Train Passengers 0	48. Other 0	50. Was EOT Device Properly Armed? 1. Yes 2. No 1		
49. Fatal 0		49. Nonfatal N/A		51. Caboose Occupied by Crew? 1. Yes 2. No 2		
<b>OPERATING TRAIN #2</b>						
52. Type of Equipment Consist (single entry) 1. Freight train      4. Work train      7. Yard/switching 2. Passenger train      5. Single car      8. Light loco(s). 3. Commuter train      6. Cut of cars      9. Maint./inspect.car		A. Spec. MoW Equip. Code 9	53. Was Equipment Attended? 1. Yes 2. No 1		54. Train Number/Symbol XTGC	
55. Speed (recorded speed, if available) Code R - Recorded E - Estimated      5      MPH      E		57. Method(s) of Operation (enter code(s) that apply) a. ATCS      g. Automatic block      m. Special instructions b. Auto train control      h. Current of traffic      n. Other than main track			57a. Remotely Controlled Locomotive? 0 = Not a remotely controlled 1 = Remote control portable	



108. DRAW A SKETCH OF ACCIDENT AREA INCLUDING ALL TRACKS, SIGNALS, SWITCHES, STRUCTURES, OBJECTS, ETC., INVOLVED.

Oneida  
2.jpg



## 109. SYNOPSIS OF THE ACCIDENT

A eastbound CSX freight train with 109 cars collided with a CSX geometry test truck on November 1, 2005, at 2:44 p.m., est. The accident occurred near Oneida, NY, at CSX Milepost QC 266, on the CSX Albany Division, Mohawk Subdivision, in Oneida Yard. Yard rules are in effect on the Oneida Yard Track.

There were no injuries to the train crew or occupants of the high-rail vehicle. The leading locomotive sustained minor damages of \$100.00, and there was no derailment. The high-rail vehicle derailed and sustained damages of about \$140,000.00.

At the time of the accident it was daylight, with a light rain falling. The temperature was approximately 50 degrees (F).

The accident was caused by failure of the locomotive engineer to comply with an interlocking signal displaying a stop indication.

The investigation revealed that the train operated past the Stop Signal at CP 266, without permission, at 50 mph and diverged onto the Oneida Yard Track and struck the high-rail vehicle at 47 mph. The locomotive download indicated that an emergency application of the air brakes was not initiated until 391 feet after the engine passed the Stop Signal at CP 266. The sight distance to the Stop Signal to CP 266 was measured at approximately 7,989 feet. The crew stated that the approach signal to CP 266 displayed Clear, which would indicate proceed at maximum authorized speed, not requiring the train to be prepared to stop at CP 266. CSX instituted a 24-hour watch on the signal system, which did not reveal any anomalies. The computer records from the dispatching center, which control the signal system, confirm that the eastbound Home Signal at CP 266 was placed in the Stop position and a blocking device applied to protect the high-rail vehicle movement. The results of the signal tests and the dispatching center records contradict the crews statement regarding the approach signal at Milepost QC 268.

## 110. NARRATIVE

The following information was obtained from an investigation that was performed by the Federal Railroad Administration.

## Circumstances Prior to the Accident

The crew of train CSX Q626-31 East included a locomotive engineer and a conductor. They went on duty at 10:30 a.m., EST, November 1, 2005, at the CSX DeWitt Yard in Syracuse, NY. This was the home terminal for the crew members. The engineer had been off duty 10 hours and 15 minutes and the conductor had been off duty 36 hours and 45 minutes prior to this trip, which is more than the statutory off duty period.

Their assigned freight train consisted of two locomotives, 48 loaded and 61 empty cars of mixed freight. It was 6,000 feet long and weighed 7,575 tons. The train was destined for Selkirk, NY. The train received a Initial Terminal air brake and end-of-train (EOT) device test prior to departing DeWitt Yard.

The locomotive engineer was seated at the controls on the south side of the cab and the conductor was seated on the north side of the cab.

The train crossed over from Main Track No.1 to Main Track No. 2 at CP 270. The signal displayed a limited clear indicating the train could proceed at limited speed through the interlocking. The locomotive engineer called the limited clear over the radio as required by CSX Operating Rule No. 34-A-2, effective November 1, 2005.

The train continued to operate to the intermediate signal at milepost 268. According to the train crew, the signal indication was proceed. The engineer stated that he did not recall communicating the indication of the signal to the conductor, which is required by CSX Operating Rule No. 34A-1, effective November 1, 2004. The track in the accident area is a double main line running in a west to east direction between milepost 269 and 265. The track is tangent from milepost 268.4 to 265.5 with a 0.25- percent ascending grade from milepost 268.7 to 267, then 0.25-percent descending grade to milepost 265.6. In the area of the accident, there is a Controlled Siding north of main track number 2 and the Oneida Yard track is north of the Controlled Siding. The method of operation approaching the accident area is Automatic Block Signal Rules (ABS), signaled in both directions leading to the interlocking at CP 266, where the method of operation is Control Point Signal Rules (CPS).

The crew of the hi-rail geometry vehicle (OTE XGT- 5) included a operator and a track inspector. They both

went on duty at 7:00 a.m. on November 1, 2005. They were assigned to measure track gauge and crosslevel on the Controlled Siding westbound between CP 263 and 266. They held movement form EC-1 No. 156, which went into effect at 1:59 p.m. This movement authority gave them permission to operate on the Controlled Siding between CP 263 and 266 and Main Track No. 2 track between the West Absolute Signal (WAS) and East Absolute Signal (EAS) at CP 266, with a crossover move at CP 266 from the Controlled Siding to Main Track No. 2.

The hi-rail operator and track inspector were experiencing some problems with the testing equipment and asked for and received verbal permission from the dispatcher to back down the yard track with the intentions of taking the hi-rail vehicle off at a nearby crossing. At the time of the accident, the hi-rail vehicle operator was in the process of clearing in on the Oneida Yard track at CP 266.

The railroad timetable direction of the train and the hi-rail vehicle was east. The geographic direction was also east. Timetable directions are used throughout this report.

#### The Accident

Train CSX Q626-31 was traveling east on Main Track No. 2 at 50 mph approaching the accident area. The crew had an unobstructed view of approximately 7,989 feet to the EAS at CP 266, which displayed a stop indication. The engineer stated that he didn't see the stop signal until he was right on top of it and noticed the hi-rail vehicle on the yard track. Prior to impact, he saw two people jump from the hi-rail vehicle.

The event recorder indicated that the engineer initiated an emergency application of the air brakes approximately 391 feet east of the signal at CP 266. At that point, the train was half-way through the interlocking. The switches were lined for the Controlled Siding and the Oneida Yard Track. The engineer announced an emergency broadcast three times over the radio.

The train impacted the hi-rail vehicle at approximately 47 miles per hour. At the point of impact the high-rail vehicle was located 18 feet east of the siding switch frog, which was 1,066 feet east of the EAS.

The truck came to rest 267 feet east of the point of impact, between the Oneida yard Track and the Controlled Siding. The train continued down the yard track another 1,495 feet, coming to rest 2,561 feet east of the EAS. The dispatcher heard the emergency call and asked who had made the transmission. The crew identified themselves and said they had struck a track vehicle on the siding at Oneida. The dispatcher called an ambulance and notified his superior. The engineer got out and went to check on the men, the conductor stayed on the engine to stay in contact with the dispatcher.

The crew of the OTE XGT-5 approached the west end yard track and saw the train coming but assumed the train was going 10 mph for the slow order that was in effect on the defective frog on the No. 2 track at CP 266. The testing equipment stopped working as they approached the switch so the operator decided to set the truck off on the yard track crossing and proceeded to stop just west of the yard track switch and called the dispatcher and received permission for a reverse move to the yard track. While making the reverse move at about 3-5 mph through the switch, the operator was looking in the side view mirror to protect the move and the track foreman yelled to "jump, the trains coming at them". Both occupants escaped by a few feet prior to impact.

The track foreman was taken to Oneida Hospital and released.

The operator of the high-rail went to a healthcare center later and was treated for soreness and a strain of the lower back and neck caused from jumping from the vehicle.

#### Analysis and Conclusions

Interviews with the Conductor and Engineer of CSX Train Q626-31 both state that the Approach Signal for CP 266 which is located at mileage QC268, 2 miles west of CP 266 was clear. The engineer stated that he proceeded to CP 266 and at the last second saw the three headed signal mast all red, saw the track car and

threw the train in emergency. The conductor stated that he was checking his paperwork and didn't notice the stop indication, only when the engineer placed the train in emergency did he notice the track car and that the switches were lined for the side track.

CSX put a 24 hour watch on the signal system and reported no problems.

Analysis from the dispatch diagnostic log from CAD at Selkirk verified the following.

At 14:39:35 The approach track indication 4EAK displayed on dispatcher display [ 4EAK is the track circuit between Signal 268E and EAS 4E]

At 14:41:24 Dispatcher removed route blocking.

At 14:41:29 Dispatcher requested No. 5 switch reverse to move High-Rail vehicle from control siding to Oneida yard track.

At 14:41:38 Switch No. 5 indicates reverse- High-Rail moved towards Oneida yard track.

At 14:42:01 Indication received that "switch occupied no route requested" [No signal 4EAS was requested or displayed]

Subsequently 14:42 and unknown seconds the impact occurred.

Signal 2682E verified to display approach [yellow over red] when 4EAS at stop.[red over red]

#### Probable Cause and Contributing Factors

The FRA determined the probable cause of the accident was the failure of the locomotive engineer to comply with an interlocking signal displaying a stop indication.