The Accident

On February 20, 2016, about 6:10 a.m., Norfolk Southern Railway Company (NS) train 298 struck and killed a NS terminal trainmaster in New Orleans, Louisiana. The train was operating on main track 2 at milepost 186 of the Alabama division, NE subdivision. At the time of the accident, the trainmaster was most likely placing a shunt on main track 2 to perform a train-crew efficiency test. The National Weather Service had issued a dense fog advisory for the area from 4:00 a.m. until 9:00 a.m. on the day of the accident. Visibility was reported as 1/4 mile in dense fog.

The accident occurred on double main-track territory. Train operations were governed by NS operating rules, effective January 1, 2015; Alabama Division Timetable Number 1, effective August 4, 2008; and signal indications of a traffic control system. Several operations bulletins were also in effect. A minimum of 10 freight trains and 2 Amtrak trains operated through the accident location daily, and the maximum authorized speed was 60 mph.

According to initial statements made by the train crew to Federal Railroad Administration (FRA) Region 5 inspectors, as the train approached the trainmaster, the engineer observed a yellow object in the track, about five car-lengths ahead, and initiated an emergency brake application. It appeared that the trainmaster was lying face down across the east rail of main track 2. The trainmaster was found wearing a safety vest; and a lantern, safety glasses, shunt wire, radio, and company cell phone were also found at the scene. The speed of the train at the time of the accident was reported to be about 58 mph.

Analysis of the forward-facing video obtained from the head end of the striking locomotive indicated the trainmaster was laying across the east rail prior to being struck by the train. There was no obvious movement by the trainmaster while he was visible in the video—about 5 seconds. There was no direct evidence of a medical event in this accident; however, investigators could not rule out the possibility of incapacitation by either an injury or a medical condition.

The 26-year-old trainmaster had worked at the New Orleans NS facility for about 4 months, and was a junior-level manager who recently graduated from the NS management trainee program. His first position with NS was as a trainmaster and he was assigned and qualified under Title 49 Code of Federal Regulations (CFR) Part 217 (railroad operating rules) in October 2015. He was also qualified under NS operating rules in December 2014.

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1 Shunting involves making an electrical connection between the two running rails to simulate the presence of a train, typically with a cable. Shunting causes the signal system to display stop indications to trains approaching the area where shunts are applied.

Note: This report was reissued on April 3, 2017, with corrections to page 2.
Norfolk Southern Railway Employee Fatality

According to FRA Region 5 inspectors, under the NS division superintendent’s guidance and instructions, B-3 managers were not to conduct main line banner tests without the presence of a senior-level manager. According to the NS terminal superintendent, the banner that would have been used for a train-crew efficiency test was still in the trainmaster’s vehicle at the time of the accident.

According to the terminal supervisor, the trainmaster participated in a morning call at the Oliver Yard office at 5:15 a.m. During this call, the trainmaster did not mention his intention to go to the location where the train struck him. The trainmaster left the yard about 5:38 a.m. His shift started on February 19 at 6:00 p.m. and was scheduled to end on February 20 at 6:00 a.m.

Postaccident Action

On March 4, 2016, NS released an internal safety alert to employees describing the facts of the accident. The safety alert included tips to remind employees to exercise caution around the right of way.

Probable Cause

The National Transportation Safety Board determines that the probable cause of the accident was the trainmaster not detecting the presence of an oncoming train and removing himself from main track 2 for unknown reasons.

For more details about this accident, visit www.ntsb.gov/investigations/dms.html and search for NTSB accident identification DCA16FR003.

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2 B-3 managers are junior-level managers. A banner test is conducted to test a train crew’s compliance with restricted speed. To conduct this test, a trainmaster will place an obstruction (sometimes called a banner) on the track ahead of a train that is required to proceed at restricted speed on a main track. The obstruction is large enough for a train crew to see in plenty of time to stop the train. Reflective tape is used for nighttime tests.
The NTSB has authority to investigate and establish the facts, circumstances, and cause or probable cause of a railroad accident in which there is a fatality or substantial property damage, or that involves a passenger train. (49 U.S. Code § 1131 - General authority)

The NTSB does not assign fault or blame for an accident or incident; rather, as specified by NTSB regulation, “accident/incident investigations are fact-finding proceedings with no formal issues and no adverse parties … and are not conducted for the purpose of determining the rights or liabilities of any person.” 49 Code of Federal Regulations, Section 831.4. Assignment of fault or legal liability is not relevant to the NTSB’s statutory mission to improve transportation safety by investigating accidents and incidents and issuing safety recommendations. In addition, statutory language prohibits the admission into evidence or use of any part of an NTSB report related to an accident in a civil action for damages resulting from a matter mentioned in the report. 49 United States Code, Section 1154(b).