On May 14, 1997, about 9:00 p.m., central daylight time, a Missouri and Northern Arkansas Railroad (M&NA) train, the Cotter North local, was traveling northbound in nonsignaled territory when it entered a siding track and collided with an unattended and unoccupied Branson Scenic Railway (BSR) excursion train. The collision occurred in downtown Branson, Missouri, on the M&NA Aurora Subdivision at milepost (MP) 447.3. When the collision occurred, the lead locomotive unit of the striking train derailed and caught fire. Also, both locomotive units of the parked train derailed. Both train crewmembers of the M&NA train sustained minor injuries. The costs associated with the accident were $410,625.

The M&NA train was traveling northbound at a recorded speed of 26 mph. As the train came around a sharp left-hand curve, the train crew observed that the switch leading into the depot track at Branson was lined for the depot track. The engineer made an emergency brake application, but the train did not stop in time, continued into the depot track, and collided with the parked excursion train.

Minutes after the accident, the M&NA train crewmembers and the Branson Police Captain walked to the depot track switch. They observed that the switch was lined and locked for the depot track with a BSR blue signal\(^1\) lock. The M&NA switch lock was on a chain that was attached to the switch stand and was not being used to lock the switch.

\(^1\) Blue signal is a railroad term that is described in the 49 Code of Federal Regulations Part 218, Subpart B, “Blue Signal Protection of Workers,” which prescribes minimum requirements for the protection of railroad employees engaged in the inspection, testing, repair, and servicing of rolling equipment whose activities require them to work on, under, or between such equipment, subjecting them to the danger of personal injury posed by any movement of such equipment.
The BSR excursion train had been operated by a M&NA operating crew. The conductor stated that after the excursion train arrived at the Branson Depot for the final time, at about 3:45 p.m., he lined the switch back for the main track movement, and locked the switch handle in that position with a M&NA switch lock.

The BSR chief mechanical employee began to blue signal the track and equipment as soon as the train stopped on the depot track. He said that the BSR did not have a written policy for this procedure, however he had a routine procedure that he and the other mechanical employees used. Part of the blue signal protection procedure included the placement of a blue signal lock on the main track switch leading to the depot track. The chief mechanical employee stated that he removed the M&NA switch lock and applied the BSR blue signal lock. He also stated that he did not look at the switch point alignment or at the switch target position before he affixed his blue signal lock because he assumed that the train crew had left the switch lined in the proper position, for the main track.

Because of the conflicting statements made by the conductor and the chief mechanical employee, it could not be determined which employee did not properly align the switch. However, the chief mechanical employee was the last person near the switch prior to the accident, and he should have ensured that it was properly aligned.

The chief mechanical employee recently had some disagreements with the general manager. He felt he had been working with a department that did not have sufficient budget or staff, and that he had an enormous amount of responsibility. In his opinion, these conditions created a stressful environment. He also stated that in the 1-month period prior to the accident, he had at least three disagreements with the general manager concerning operational problems. In each case, he felt that the general manager had made poor decisions. The last of these disagreements had occurred on the day of the accident, and other employees said that the chief mechanical employee was visibly angry.

The BSR operates over the general railroad system, and all Federal Railroad Administration (FRA) regulations and safety statutes apply. However, the BSR did not have a written blue signal policy for reference or training. The chief mechanical employee stated that he did not have any written policy or rule for a lock out protection procedure, but he did have some procedures in place that he had learned through experience. The FRA should have noted this deficiency during their inspections, and required the BSR to have a written policy, and to train their employees accordingly.
PROBABLE CAUSE

The National Transportation Safety Board determines that the cause of this accident was the failure of the BSR chief mechanical employee to ensure that the switch was properly lined before applying the blue signal lock because he was preoccupied with disagreements that he had with the BSR general manager.

Adopted: April 23, 1998