Issued: October 14, 2025 Railroad Investigation Report: RIR-25-15

Union Pacific Railroad Conductor Struck and Killed by METRA Train

Location	Kenosha, Wisconsin
Date	September 4, 2024
Accident type	Employee fatality
Southbound Striking Train	METRA Passenger Train M338 3 crewmembers, unknown number of passengers 1 locomotive, 6 passenger railcars
Northbound Stopped Train	Union Pacific Freight Train MCHAL-04 3 crewmembers 3 locomotives, 110 mixed manifest railcars
Track	Double-main track with positive train control
Hazardous materials	Ferric chloride, sulfuric acid, elevated temperature liquid, N.O.S. (asphalt), molten sulfur, ethanol, basic corrosive liquid, inorganic N.O.S., molten phenol
Fatalities	1
Injuries	0
Property Damage	No monetary damage

Summary

On September 4, 2024, about 12:11 p.m. local time, the conductor of northbound Union Pacific Railroad (UP) train MCHAL-04 was struck and killed by southbound METRA commuter train M338 at milepost (MP) 50.57 of the UP Kenosha Subdivision near Kenosha, Wisconsin.[1] (See figure 1.) There were no other fatalities or injuries. At the time of the accident, the temperature was 79˚F with no precipitation. Skies were clear with midday light.

[1] (a) Visit ntsb.gov to find additional information in the public docket for this NTSB accident investigation (case number RRD24FR016), including detailed factual reports about the circumstances of the accident. (b) All times in this report are local. (c) METRA, short for Metropolitan Rail, is the commuter railroad division of the Regional Transportation Authority.

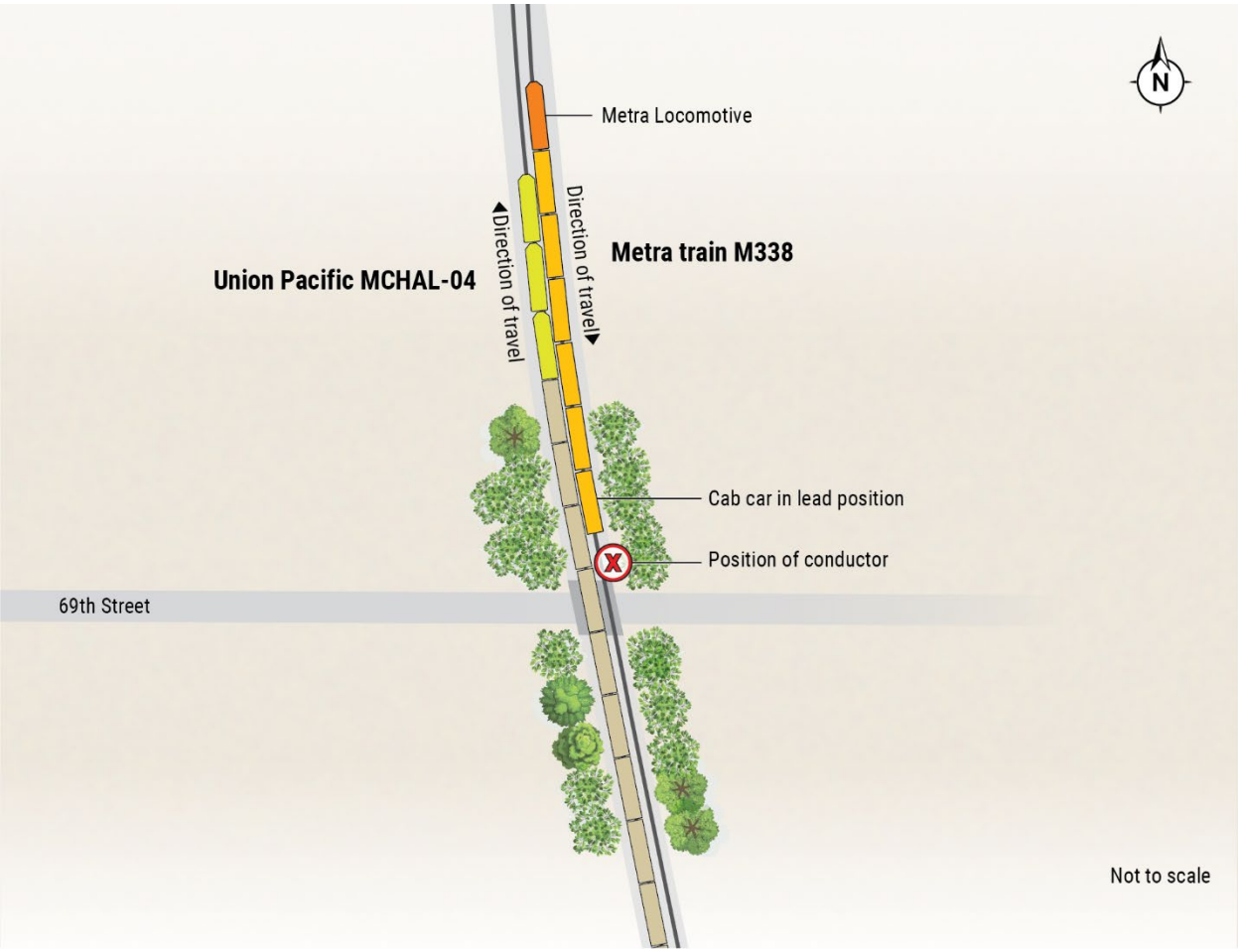

Figure 1. Accident scene.

A student engineer was operating train MCHAL-04 on Main Track 1 as it passed through a wheel temperature detector (WTD) at MP 46.17, which detected a hot wheel issue with the 51st railcar on the train.[2] In an interview with National Transportation Safety Board (NTSB) investigators, the engineer said that after receiving a hot wheel alert from a UP dispatcher at 11:58 a.m., the train crew held a short discussion in the locomotive cab in which they determined that the next WTD was located more than 30 miles away from

[2] (a) The crew of MCHAL-04 consisted of an engineer, a student engineer, and a conductor; the crew of METRA train M338 consisted of an engineer, a brakeman, and a conductor. (b) A *wheel temperature detector* is a device typically installed along railroad tracks to identify overheated wheel components on passing trains through the use of infrared sensors for measuring the temperature of each wheel as the train rolls by. (c) A *hot wheel* on a railcar refers to the overheating of its wheels, which can cause the wheels to crack if the overheating is severe.

its location at the time.[3] Therefore, in accordance with UP procedures, the conductor contacted the dispatcher and requested permission to stop and inspect "in Kenosha"; although the dispatcher granted permission for the train to stop, a specific location was not provided.

In an interview with NTSB investigators, the student engineer said that the crew held a job briefing to discuss where to stop the train to examine the wheel identified as being hot, wanting to make sure that the train was not blocking any train platforms or highway-railroad grade crossings. The student engineer said that the plan was for him to stop the train for the conductor to exit. He would then slowly move the train forward on Main Track 1 until the 51st railcar was in front of the conductor for the wheel examination. As planned, the conductor exited the locomotive at 12:05 p.m. However, he dismounted the train toward the adjacent Main Track 2, in opposition to UP operating rules. He then walked across the adjacent Main Track 2 and took up a position standing on the end of the crossties outside of the rails on the east side of the Main Track 2 as the student engineer moved the train forward.[4] (See figure 2.) There was no barrier or impediment on the clear side of the track.

[3] (a) A *hot wheel alert* is a notification provided to a train crew to inform them that a hot wheel has been detected on the train. (b) UP regulation 13.1 K requires that if the train will not pass over a second WTD within 30 miles, the train crew request that the dispatcher identify a safe location for them to stop and inspect the train.

[4] An *adjacent track* is a set of tracks whose center is spaced less than 25 feet from the center of the occupied track. However, it is often used to refer to any track that is located close to another track.

Figure 2. Exemplar photograph of the conductor's position at the time of the accident.

Both the engineer and the student engineer acknowledged in interviews with NTSB investigators that during this movement, their focus was on training the student engineer on the train maneuver he was performing, rather than on the actions of the conductor or watching for trains approaching on the adjacent track.

Meanwhile, METRA train M338, left Kenosha station at 12:08 p.m., traveling southbound. Event recorder and video recordings indicated that the train was traveling at 53.6 mph when it rounded a curve north of the UP conductor's position and the UP conductor come into the view of the METRA train operator about 670 feet away. Upon

identifying the UP conductor standing in the foul of the track, the METRA operator immediately sounded the horn and initiated an emergency brake application. However, by the time the operator of the METRA train spotted the UP conductor and applied the brakes, there was not enough time for the train to come to a complete stop before striking the conductor.

Analysis

The conductor of UP train MCHAL-04 was struck by METRA train M338, operating as he stood on the ends of the rail ties of Main Track 2 waiting on the railcar with the identified hot wheel to be pulled to his location for further examination.[5] The conductor dismounted the locomotive toward the adjacent Main Track 2 rather than away from it. This was a violation of UP operating rule 81.4.1 which states that employees should get on or off equipment on the side away from active tracks.

In addition to the conductor's decision to inappropriately dismount to the side of his train with active track, the NTSB determined that the crew of UP's train MCHAL-04 made several errors which, when combined, led to the accident. Freight trains rarely operate on the Kenosha Subdivision, and track breach protection was not used because they thought it was not allowed at this location as it could delay METRA's passenger trains, which took priority on the tracks.[6] In an interview with NTSB investigators, the engineer of MCHAL-04 said that they were not very familiar with the section of track they were operating on because UP rarely runs freight trains on that particular route. In interviews, the crew said that they chose to stop their train where they were instead of moving elsewhere because their current location did not interfere with any grade crossings or platforms. They did not consider other factors such as visibility distances and the potential for encountering approaching trains.

Job briefings are intended to communicate useful information so that everyone on the crew is prepared to perform their work efficiently, effectively, and safely. Job briefings are required to include the work to be done, potential hazards the crew may encounter, and effective ways to remediate those hazards. Although the crew of MCHAL-04 held a job briefing before commencing with the examination of the hot wheel, the NTSB identified shortcomings in the briefing as it did not include information

[5] A *cab car*, also sometimes known as a control car, is a nonpowered rail vehicle from which a train can be operated. Since METRA train M338 was led by the cab car, its approach was not as loud as it may have been had it been led by a locomotive.

[6] *Track breach protection* allows employees to occupy the area between adjacent tracks by restricting train movements through the area.

about other scheduled train traffic on the line nor a safe location for the conductor to station himself while his own train pulled forward.

The engineer and student engineer were responsible for the operation of the train, and for observing conditions outside the locomotive that could affect their operations. To execute this duty, they should have been cognizant of the conductor's location as well as monitoring for oncoming trains on the adjacent track that could affect their conductor's activities. Evidence from the locomotive's in-cab camera showed that while the conductor was readying to examine the potential hot wheel on the 51st railcar, the engineer and the student engineer were conducting other functions associated with operating the train and were not being vigilant as to what was happening outside their train on the adjacent track that could affect the conductor's work. A review of the train's outward-facing camera and sight-distance testing showed that had the crew been vigilant to activities outside the train that could have affected the conductor's wheel inspection, they had as much as 19 seconds to warn the conductor by radio of the oncoming METRA train.

Probable Cause

The National Transportation Safety Board determines that the probable cause of the accident was the conductor of Union Pacific Railroad train MCHAL-04 being struck by METRA train M338 when fouling the adjacent track for unknown reasons. Contributing to the accident was the failure of the crew of train MCHAL-04 to conduct a comprehensive job briefing that would have alerted the conductor to the risks he was facing while in the foul of the track waiting to conduct the wheel inspection. Also contributing was the failure of the engineer and student engineer of train MCHAL-04 to maintain situational awareness of the conditions outside of the locomotive, which would have enabled them to provide warning to the conductor, via the radio, of the approaching METRA train.

Lessons Learned

Following the accident, UP issued an incident alert to its employees discussing the circumstances of this accident and reminding them of the applicable rules that must be adhered to in order to prevent this type of accident.

At the time of this accident, UP did not require track breach protection on the Kenosha Subdivision. Following the accident, on September 12, 2024, UP updated its system special instructions for track breach protection, which restricts trains from moving within the area, to be in effect where railroad employees are working on the ground, enabling them to safely occupy the area between the tracks on the Kenosha Subdivision.

In addition, the Switching Operations Fatality Analysis (SOFA) Working Group published an alert in June 2025 discussing the importance of comprehensive job briefings. It indicated that employees being struck by mainline trains is one of the most

common findings in switching operations fatalities and that 20 percent of those involved an inadequate job briefing.

These postaccident actions affirm the importance of crews developing and maintaining situational awareness of the safety risks that surround wheel inspection operations.

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For more detailed background information on this report, visit the NTSB Case Analysis and Reporting Online (CAROL) website and search for NTSB accident ID RRD24FR016. Recent publications are available in their entirety on the NTSB website. Other information about available publications also may be obtained from the website or by contacting—

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