



Issued: January 26, 2026

Railroad Investigation Report: RIR-26-03

Hulcher Services Inc. Employee Injury

Location	Stockton, California
Date	March 11, 2025
Accident type	Railroad contractor injury
Track	Port of Stockton, Track 840
Hazardous materials	None
Fatalities	0
Injuries	1

Summary

On March 11, 2025, about 3:00 p.m., a Hulcher Services Inc. (HSI) assistant division manager trainee (ADMT) sustained serious injuries during a rerailing operation at the Port of Stockton in Stockton, California.¹ (See figure 1.) The injured ADMT was part of an eight-person HSI crew contracted by the Central California Traction Company (CCT Railroad) to rerail four railcars that had derailed the day before at a switch on Track 840.² During the rerailing task, the ADMT stepped between a rubber tire loader and a railcar to release a hand brake, causing the railcar to roll toward the loader. As the equipment collided, the ADMT was pinned between the end of the car and the loader. At the time of the accident, visibility conditions were clear, unobstructed, and sunny; the weather was 69°F with no precipitation.

¹ (a) Visit ntsb.gov to find additional information in the [public docket](#) for this NTSB accident investigation (case number [RRD25FR008](#)), including detailed factual reports about the circumstances of the accident. (b) An ADMT at Hulcher Services Incorporated refers to an apprentice, driver, mechanic, or laborer/operator who is certified to work for all Class I railroads and whose main function is to perform general and specialized labor tasks supporting Hulcher's core services.

² CCT Railroad performs switching for the Port of Stockton.



Figure 1. Overhead view of the Port of Stockton and (inset) a still frame showing the accident. (Source: Google Earth; inset source: Port of Stockton security camera footage.)

On the evening of March 10, 2025, about 7:00 p.m., four CCT Railroad cars derailed during a shoving movement in which a total of 27 cars were being relocated to an industrial spur at the Port of Stockton rail facility: three of the derailed cars were upright and one was leaning.³ The derailment likely occurred as the result of a broken switch point on the industrial lead combined with a worn wheel on one of the derailed cars.

About 7:40 p.m. on March 10, CCT Railroad personnel contacted HSI to discuss the derailment and establish a plan for contracting an HSI crew to rerail the four cars the following day. The HSI crew arrived the following day to evaluate the task and prepare

³ An *industrial spur* refers to a track that diverges from the main or other tracks to provide access to industrial or commercial areas and usually ends within an industry area.

the loader and other heavy equipment for the task of rerailing the four cars. Equipment used by the HSI crew included one loader and two side booms.⁴

In interviews with the National Transportation Safety Board (NTSB), crew members described the events of March 11, 2025, before the accident. According to interview testimony, once the crew completed their task assessment, the ADMT led a job safety briefing with the rest of the HSI crew. The job safety briefing covered the guidelines for working around heavy equipment, pinch points, track protection, personal protective equipment, and emergency services.⁵ After the safety briefing, CCT provided track protection for the crew, and the crew then began moving the 15 non-derailed cars on the west side of the derailment further down the track so that room could be made to rerail the four derailed cars.

Next, the crew rerailed the two easternmost derailed cars and moved them further east on the track. Car CPXX 1025 was the westernmost derailed car and was the next in the sequence to be rerailed. After rerailing, it was determined that car CPXX 1025 needed to be relocated further west of its current position on the track to make room for rerailing the leaning car, which was the last of the four cars to be rerailed. (See figure 2.) The ADMT informed the loader operator that they both would be repositioning CPXX 1025 further west on the track while the rest of the crew prepared to rerail the leaning car.

⁴ (a) A *loader* is a type of heavy equipment with a large front bucket used to scoop, lift, and move materials. (b) A *side boom* is a specialized crawler tractor outfitted with a side-mounted boom, counterweights, and winch systems.

⁵ A *pinch point* refers to any point where it is possible to be caught between movable parts of equipment.



Figure 2. Accident car CPXX 1025.

According to interview testimony and surveillance video, the loader was positioned on the west end of car CPXX 1025 with the cab of the loader facing east, providing the loader operator with a clear view of the area in front of him. The ADMT then walked between railcar CPXX 1025 and the mast of the loader to chain the car and the loader together.⁶ Once the chain joining the railcar to the loader was secure, the ADMT stepped out from between the equipment and instructed the operator to take the slack out of the chain by reversing the loader slightly. The ADMT then positioned himself back between the equipment, pulled the rail car's quick release on the hand brake, and railcar CPXX 1025 began to roll westward toward the mast of the loader. The ADMT, still positioned between the railcar and the loader, while attempting to reapply the railcar's hand brake, was struck and crushed between the end of the railcar and the loader.

⁶ Because of close clearances on the sides of the track, the bucket had been removed from the loader. The rubber tire loader is equipped with a quick-change system for attachments; with the bucket removed, the loader side of the quick-change system is exposed, and this part is called the *mast*.

Immediately after the accident took place, another HSI crew member working at the other end of car CPXX 1025 rushed over and pulled the injured ADMT out from between the loader and the railcar while another crew member contacted emergency services. The ADMT was transported and admitted to the local hospital, where he was treated for six fractured ribs, a collapsed lung, and fluid in his lungs.

Analysis

In this accident, an ADMT sustained serious injuries when he was pinned between a loader and a railcar during a rerailing operation.

After NTSB investigators considered weather conditions, examined all equipment and surveillance camera footage, reviewed training programs and company policies, conducted crew interviews, and staged an accident reenactment, the following issues were excluded as causal to the accident: (1) weather, (2) mobile phone usage, (3) the mechanical condition of the car, and (4) the condition of the track.

As part of the investigation, NTSB investigators reviewed HSI safety training practices and asked HSI crew members about the proper procedure to chain a rail car to a loader and how to operate a hand brake. HSI employees stated during interviews that they are trained in the field to operate the hand brake of a railcar from the brake platform and not from the ground. The employees, including the injured ADMT, all clearly understood the proper way to perform these tasks, why they were supposed to perform the tasks in a certain manner, and where to find reference material if there were any concerns. The NTSB determined that the HSI hand brake operation field training was effective, and all HSI crew members were aware of how to safely operate a hand brake.

Rules specific to hand brake operations are found in the Safe Practices Handbook under rules 2600 through 2610. The written instructions did not clearly specify where an employee should be physically positioned to operate a hand brake, however. Rule 109, which pertains to pinch points, is very specific that employees shall avoid placing their body between two objects that could come together, causing them to be pinched or smashed, but hand brake operating rules were not as clearly defined. Although HSI employees were trained to operate the hand brake of a railcar while standing on the brake platform and not standing the ground, the hand brake operation rules and Standard Operating Procedure 33, *Railcar Safety and Operations*, do not include any language pertaining to where employees should position themselves to operate a hand brake. This lack of clear written instruction for how to operate a hand brake, regardless of the locally trained practice, demonstrates that there is a gap between written safety procedures and local training demonstrations that can lead to crew members interpreting the proper application of rules on their own.

Probable Cause

The National Transportation Safety Board determines the probable cause of the March 11, 2025, Hulcher Services Inc. employee injury at the Port of Stockton was

Hulcher Services Inc. lack of a standardized process for how and where to be safely positioned when operating a hand brake, which led the injured assistant division manager trainee to place himself in an unsafe position between a car and a piece of equipment while standing on the ground as he released the hand brake, resulting in crushing injuries.

Lessons Learned

This accident underscores the critical importance of a standardized process for how and where a crew member is positioned to safely operate a hand brake.

After the accident, HSI added a new rule to the Safe Practices Handbook and incorporated it into their Standard Operating Procedure 33. This rule covers where an employee should position themselves to operate a hand brake safely. Specifically, the rule explains that the hand brake or quick release lever should always be operated from the brake platform when turning by hand. Further, the rule explains that under no circumstances should the hand brake or quick release lever be manipulated from the ground at the end of car, while positioned between cars or equipment, or from any position where movement of cars or equipment would put an employee in a pinch point. This change in the rules was incorporated into the daily safety briefing and training practices both in the field and at the HSI headquarters training facility.

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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” (Title 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 (Title 49 United States Code section 1154(b)).

For more detailed background information on this report, visit the [NTSB Case Analysis and Reporting Online \(CAROL\) website](#) and search for NTSB accident ID RRD25FR008. 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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