Issued: April 2, 2026 Railroad Investigation Report: RIR-26-04

R.J. Corman Railway Group Conductor Injury

Location	Guthrie, Kentucky
Date	June 26, 2025
Accident type	Conductor Injury
Accident train	Freight train MG 20 2 crewmembers 1 locomotive,13 railcars
Track	Other than main track, non-signalized
Hazardous materials	None
Injuries	1

Summary

On June 26, 2025, about 5:00 p.m. local time, an R.J. Corman Railway Group conductor was seriously injured during a railcar switching operation at Guthrie Yard in Guthrie, Kentucky.[1] The conductor was working with an engineer to separate a damaged railcar from a block of 13 railcars and move it onto a siding track east of the main track. During the switching operation, the conductor suffered a serious injury to his foot when he placed it between equipment to push the knuckle of a coupler into alignment. Visibility conditions at the time of the accident were clear, unobstructed, and sunny. The weather was 91°F with no precipitation.

On the day of the accident, the R.J. Corman crew, consisting of a conductor and an engineer, of local train MG20 went on duty at 6:30 a.m. in Guthrie, Kentucky, on the R.J. Corman Memphis Line. Shortly after coming on duty, the crew reviewed their required daily paperwork and performed a job safety analysis, which discussed, among other things, extreme temperatures, proper hydration, and taking breaks as needed to prevent heat injuries.

The crew's task for the day was to pick up railcars from private customer facilities located along the R.J. Corman Memphis Line and move them to Guthrie Yard where they would be dropped off and prepared for further transportation. While switching, the couplers between two railcars bypassed each other and damaged the uncoupling lever

[1] Visit ntsb.gov to find additional information in the public docket for this NTSB accident investigation (case number (RRD25FR016), including detailed factual reports about the circumstances of the accident.

of one of the railcars at a customer facility.[2] The crew reported the damage to their field manager. Once they determined that the railcar was safe to move, the crew was instructed by the field manager to move the damaged (bad order) car to the Guthrie yard.

During the process of setting out the bad order railcar, the conductor lined the switch and instructed the engineer to begin a reverse move of about 253 feet.[3] The conductor positioned himself next to the stationary car into which they were preparing to couple. The conductor stated in his interview that he believed the last railcar of the moving train was about 15 feet from the standing car when he saw that the knuckle of the coupler on the standing car was misaligned. To expeditiously align the couplers, the conductor reported that he decided to use his left foot to push the knuckle into alignment while the train was shoving towards the standing cars. While his foot was on the coupler of the standing car, it sustained a crushing injury when the coupler from the shoving train collided with the coupler of the standing car. (See figure 1.) During his interview, the conductor told National Transportation Safety Board (NTSB) investigators "…it was hot, close to the end of the day. I was just trying to get out of the heat, and I think, I think, that's why I did it."

Immediately after the accident, the conductor radioed the engineer to move the train to release his foot that was crushed between the equipment. Another employee heard the conversation on the radio and came to the conductor's assistance.

[2] *Bypassed couplers* refer to when the coupler assemblies of two railcars are in misalignment with one another to the extent that they will not allow a coupling to occur. When attempting to couple together railcars with misaligned couplers, the coupler assemblies will often displace their components further out of alignment, which can subsequently cause the parts of the couplers to contact and often damage the end of the car body or the appliances attached to the end of the car body including crossover platforms, uncoupling levers and air brake system components.

[3] (a) Railway switches are mechanical devices that allow trains to be guided from one track to another. (b) To set out means to remove a railcar (or multiple cars) from a train and leave it/them on a siding or track for a specific purpose.

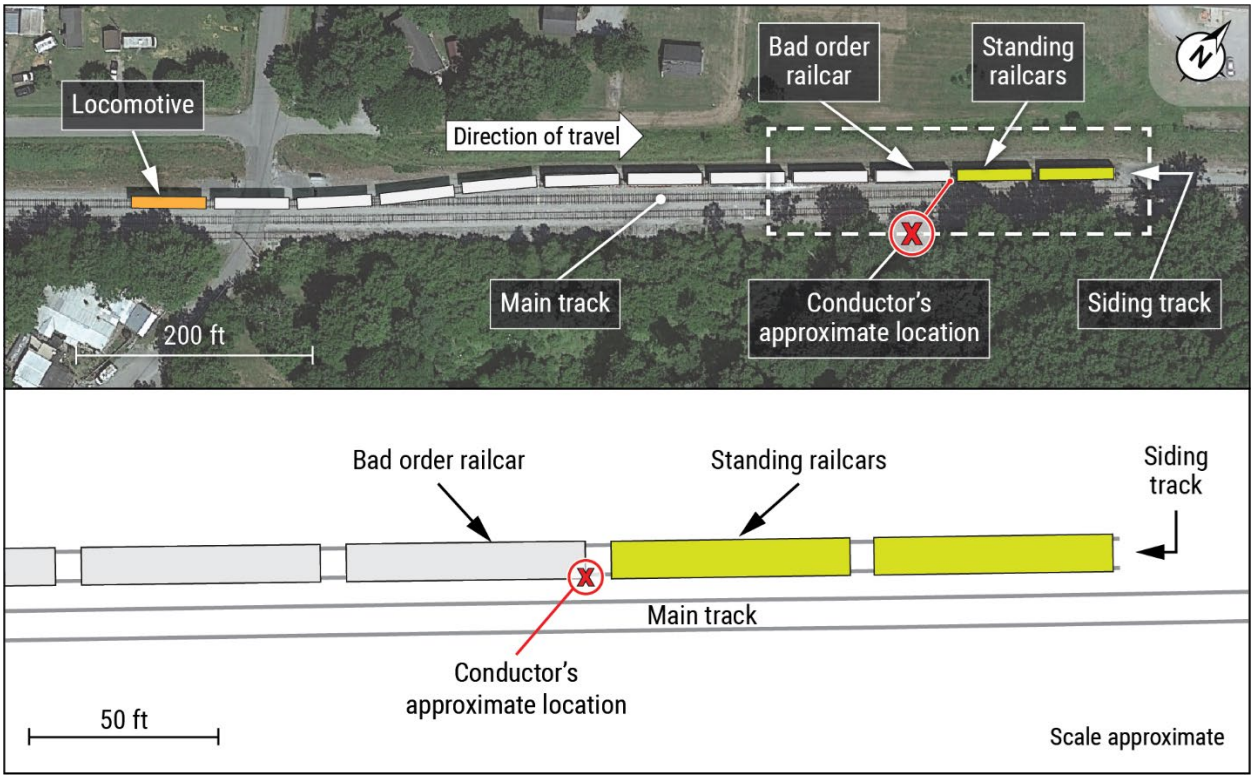

Figure 1. An aerial view of the accident site.

Analysis

As a result of the investigation, NTSB determined that neither track condition nor railcar mechanical conditions were causal in the accident.

This severe injury occurred when the conductor unsafely attempted to adjust a coupler with his foot, and without establishing appropriate protection from moving equipment. Information obtained in his interview found that the conductor decided to attempt this expeditious and unsafe realignment of the coupler, because he wanted to quickly complete the task to get relief from the day's elevated temperatures. On the day of the accident, Clarksville Regional Airport (KCKV), which was 13 miles away from the accident site, recorded a temperature of 91.4°F at 4:52 p.m. (6 minutes before the accident).

At the time of the accident, R.J. Corman had employee instructions and prohibitions in place for adjusting couplers. Specifically, Rule S-13.2.4*, Adjusting Mismatched Couplers*, states that employees:

- must have a minimum of 50 feet of separation between equipment,
- must obtain three-step protection before adjusting a coupler, and

- must not kick a coupler (knuckle).

In contravention of R.J. Corman's rule, the conductor told investigators that the foot he used to "kick a knuckle" slipped and was crushed. Further, the conductor failed to obtain three-step protection and maintain 50 feet of separation.[4] When discussing his training on the proper procedures to adjust couplers with NTSB investigators, the conductor was able to describe the correct course of action for aligning misaligned couplers and acknowledged that his actions violated the rule. He also stated that he had properly performed this same task earlier in the shift and that he had not observed other employees attempting to adjust a coupler with their feet. Therefore, NTSB does not find that the conductor's training was causal to the accident.

In the 365 days preceding the accident, NTSB investigators found routine operational testing was being conducted by R.J. Corman. Specifically, R.J. Corman testing officers observed the conductor perform 258 different individual tasks with 1 instance of rule noncompliance, thus indicating that the conductor had been regularly observed and his performance was typically in compliance with operating rules and procedures.

Probable Cause

The NTSB determines that the probable cause of the June 26, 2025, R.J. Corman employee injury at Guthrie Yard was the conductor circumventing established safety rules during coupling operations, resulting in the employee's foot being crushed between two railcars. Contributing to the incident was the extreme heat, which influenced the conductor's decision to expedite the work.

Lessons Learned

To prevent similar accidents in the future, the railroad industry must increase vigilance through enhanced supervision and other safety protocols such as increased hydration and rest during extreme weather conditions. It is critical that employees understand the importance of rules adherence and that supervisors verify employees are following established safe work protocols.

The risk associated with rail employees working between equipment was also highlighted in recent NTSB investigations of other accidents involving employees going between equipment, including a Hulcher Services Inc. assistant division manager trainee who sustained serious injuries during a rerailing operation at the Port of Stockton in

[4] Three-step protection refers to a process where railroad workers request protection, confirm that safeguards against unintended movement have been applied, then communicate that the requested protection has been established prior to going in between rail equipment to perform tasks, and no movement will take place until the employee is no longer between equipment.

Stockton, California, and the death of an American Auto Works Employee in Richmond, California, while attempting to couple railcars.[5]

To call attention to risks posed when railroad employees foul the track near unsecured equipment, in November 2025, NTSB published a safety alert discussing the importance of following operating rules related to moving between equipment.

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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 RRD25FR016. 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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[5] Follow the links for more information on these NTSB investigations: RRD25FR008 and RRD25FR009.