

American Auto Works Conductor Fatality

Location	Richmond, California
Date	April 4, 2025
Accident type	Conductor fatality
Accident train	3 crewmembers 2 locomotives, 5 railcars
Track	Other than main track, non-signalized
Hazardous materials	None
Fatalities	1
Injuries	0
Property Damage	\$0

Summary

On April 4, 2025, about 9:17 a.m. local time, a ConGlobal (CG) conductor was fatally injured during switching operations at the BNSF Railway Automotive Distribution Facility, located on the BNSF Stockton Subdivision in Richmond, California.¹ The CG switching crew was performing a shoving movement with two locomotives and five railcars on yard track 405 when the conductor became pinned between two railcars that the switching crew was attempting to couple together.² (See figure.) Visibility conditions at the time of the accident were clear with no precipitation, and the temperature was 57°F.

On the morning of the accident, a CG engineer, conductor, and brakeman reported for duty about 6:00 a.m. in Richmond to perform switching operations at the

¹ (a) Visit [nts.gov](https://www.nts.gov) to find additional information in the public docket for this NTSB accident investigation (case number [RRD25FR009](#)), including detailed factual reports about the circumstances of the accident. (b) All times in this report are local. (c) The Richmond auto facility is owned by BNSF Railway but is fully leased to American Auto Works Railroad, a subsidiary of national intermodal switching company ConGlobal.

² In a *shoving movement*, railcars are pushed—rather than pulled—by a locomotive, typically with the locomotive behind the railcars and a crew member or other means protecting the leading end to ensure the track ahead is clear.

BNSF Richmond Yard and Automotive Distribution Facility.³ After reviewing required daily paperwork and conducting a job briefing to discuss the day's assigned tasks, the crew proceeded to their locomotive. The crew's task for the day involved delivering a train to Richmond Yard and returning with 29 railcars to the Automotive Distribution Facility for switching. Upon arrival at the Automotive Distribution Facility, the crew pulled 29 railcars through track 404, secured 14 railcars there, and began switching out the remaining railcars into tracks 404, 405, and 406.

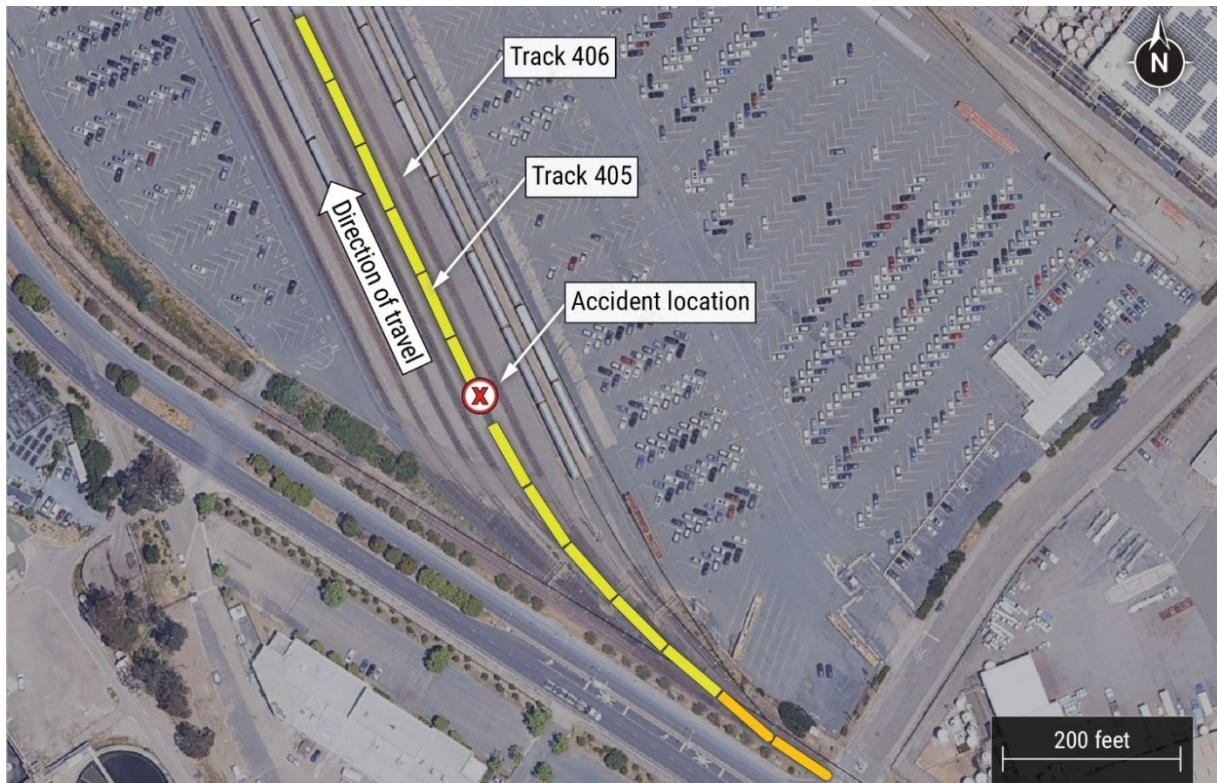


Figure. An overhead graphic depicting location of the employee and equipment.

During the switching operations, the conductor and brakeman worked together on the ground, lining switches, protecting shoving movements, and providing movement instructions to the engineer via handheld radio. Under CG operating rules, ground personnel are responsible for making railcar couplings/connections, which includes providing a countdown to the connection, stopping the movement once the railcars make a connection, and then pulling the train (briefly reversing direction, also referred to as stretching) to verify the connection has been achieved. If a bypassed coupler or drawbar condition is identified, the ground employee must stop the movement, request a minimum of 50 feet of separation, and request in-between railcar

³ *Switching operations* refers to separating or sorting railcars into tracks for further movement.

(red zone) protection from the engineer before going between railcars to correct the condition.⁴ The employee must receive positive confirmation that the movement is stopped and secured before manually realigning the drawbar. Upon completion, employees must clear the equipment, notify the engineer they are in the clear, and direct the movement to complete the coupling. After the connection is made, the ground employee instructs the engineer to stretch the joint to verify the knuckles are fully engaged and locked before authorizing normal movement to resume.

On scene, the National Transportation Safety Board (NTSB) conducted interviews and reviewed BNSF security camera footage, locomotive event recorder data, and audio recordings of radio communications. Radio communications indicated that at 9:17:18 a.m., the conductor stopped the train’s movement on track 405 after unsuccessfully attempting to couple the railcars together. The conductor then radioed the engineer to stretch, or pull the locomotive forward. The event recorder showed that the locomotive moved 6 feet. The conductor then requested “pin it,” meaning to reverse the locomotive, to try again to couple the railcars. The table below lists the radio transmissions between the conductor and engineer just before and during the accident. Of note, the engineer repeats back the conductor’s instructions to him until the 9:17:36 a.m. instruction.⁵ At 9:17:36 a.m., the conductor made his last confirmed radio transmission, again instructing the engineer to “stretch.” The engineer did not repeat or acknowledge this communication. About 30 seconds later, the engineer transmitted “bump it,” followed by “pin it” about 2 seconds later.

Table. BNSF radio communications.

Time (a.m.)	Radio command	Speaker
9:17:18	Stop	Conductor
9:17:22	All right, stretch it	Conductor
9:17:24	Stretch it	Engineer
9:17:26	Stretch 3	Conductor
9:17:31	Pin it	Conductor
9:17:35	Pin it	Engineer
9:17:36	Stretch	Conductor
9:18:06	Bump it	Engineer
9:18:08	Pin it	Engineer

⁴ *Bypassed couplers* refers to the misalignment of the coupler assemblies of two railcars to the extent that they will not allow a coupling to occur.

⁵ In railroad switching, “bump it” directs a short, low-speed movement to close the remaining distance for a coupling, while “pin it” indicates the movement should continue sufficiently for the knuckles to fully engage and lock; both commands require employees to be in a position of safety with proper protection in place.

Event recorder data show that immediately following the “pin it” transmission at 9:17:35 a.m., the engineer began shoving the train about 57 feet toward railcar TTGX 971194 (the railcar that the crew was attempting to couple to their train). After the movement stopped, the brakeman discovered the conductor crushed between the drawbars of railcars BNSF 301064 and TTGX 971194.

CG rules require red zone protection and that a minimum of 50 feet of separation between a railcar and an employee must be established before a ground crew can go between equipment and can work on misaligned couplers. Interviews and radio recordings from this accident indicate that the conductor did not request this protection, nor did the engineer establish it.

Analysis

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

During the shoving movement into track 405, the conductor protected the movement from the ground while located at the separation between railcars in track 405 and was responsible for communicating car counts and movement instructions to the engineer. The conductor provided continuous car counts as the train progressed toward railcar TTGX 971194. Upon reaching the connection location, the conductor instructed the engineer to stop and then to stretch the coupling. The engineer acknowledged the instruction and complied.

Following the stretch, miscommunication occurred between the conductor and the engineer regarding the intended movement. The conductor asked the engineer to “pin it” by radio, which the engineer properly repeated and acknowledged. Immediately after the engineer acknowledged, the conductor issued a conflicting command, “stretch it,” which was not repeated nor acknowledged by the engineer.

Event recorder data show the engineer acted on the most recent acknowledged instruction by shoving or pinning the joint. About 30 seconds later, the engineer said “bump it” over the radio, followed 2 seconds later by “pin it.” He ultimately stopped the movement 10 seconds after that, indicating his uncertainty about the railcar coupling condition and intended next action.

NTSB investigators reviewed the recorded radio communication among members of the accident train crew. The verbal instructions from the conductor to the engineer were brief and at times difficult to understand. Crew members did not effectively communicate their intentions or the status of movement protection, resulting in a lack of shared understanding and likely contributing to the failure to carry out the intended actions. Critical information was either incomplete, not timely, or not received by relevant crew members. In this case, had proper communication protocols been

followed and the required protection clearly established and confirmed among all crew members, the conditions leading to this accident would not have existed, and the incident would likely have been prevented.

A 2011 report of the Switching Operations Fatalities Analysis Working Group states: "When using radio communication, locomotive engineers must not begin any shove move without a specified distance from the person controlling the move. Strict compliance with 'distance to go' communication must be maintained." The report also notes that "the key to radio use when backing, shoving or pushing a train or cut of cars is communication between the locomotive engineer and the train crew. The crew must develop the discipline to remain stopped until specific car counts are given by the ground person, rather than to begin moving and then expect to receive the count. If this is done, fatalities related to improper radio communication can be substantially reduced."⁶

The NTSB reviewed classroom exams of the conductor, engineer, and brakeman and operational testing records related to communication and protection when working between equipment and determined that the training met standards. The NTSB found that the conductor, engineer, and brakeman correctly answered all 50 questions on their last rule exam. Within the exam are specific questions related to radio communication and the requirements for working between equipment. During the review of the conductor's operational testing records for the preceding 14 months, it was found that he was tested 162 times with no exceptions noted, indicating that the conductor had been regularly observed and that his performance typically complied with operating rules and procedures. Based on the review of the conductor's training records, the NTSB found that he not only displayed an understanding of the requirements in a classroom environment but also properly applied the knowledge in a field environment while being observed during operational testing.

Probable Cause

The NTSB determines that the probable cause of April 4, 2025, conductor fatality in Richmond, California, was the conductor going in between the railcars without the crew establishing proper protection. Contributing to the accident was the ineffective communication between the engineer and the conductor while performing switching operations.

⁶ The full report is available at [Findings and Advisories of the SOFA Working Group, Volume II, 04/2011](#).

Lessons Learned

During switching operations, clear, timely, and unambiguous communication is the most critical and reliable control available to rail crews to prevent incidents. Strengthening how crews communicate—by clearly stating intentions, verifying understanding through repeat-backs, and continuously maintaining shared situational awareness—greatly reduces exposure to hazards.

This incident also highlights the critical importance of adherence to the prohibitions against working between equipment without safety protection. Two recent NTSB investigations highlighted the risk associated with rail employees working between equipment. On March 11, 2025, a Hulcher Services Inc. assistant division manager trainee sustained serious injuries during a rerailing operation at the Port of Stockton in Stockton, California, and on June 26, 2025, an R.J. Corman conductor in Guthrie, Kentucky, was seriously injured while attempting to couple railcars.

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

As a result of this incident, CG implemented the following postaccident actions:

- Safety stand-down call with all switching leaders. The directive was given to immediately stop all operations to brief crews on the incident and to reinforce CG's "In-Between" rules with all switching employees.
- Amplified operations testing for switching, including "In-Between" protocols and radio communication according to the *CG Transportation Rail Safety Rulebook*.
- Extended pre-shift briefings with all crew members discussing the incident and associated rules.
- Increased operational testing focused on Test 102, "In Between."

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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 RRD25FR009. 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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