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Railroad Investigation Report: RIR-26-09

Union Pacific Railroad Conductor Injury

Location	Lexington, Nebraska
Date	June 25, 2025
Accident type	Serious injury of conductor
Train	One locomotive and 25 empty tank cars
Crew	Crew of yard job LFG 15-25
Track	Industry track at Chief Ethanol Fuels facility
Hazardous materials	None
Fatalities	0
Injuries	1
Property Damage	None

Summary

On June 25, 2025, about 12:33 p.m. local time, a Union Pacific Railroad (UP) conductor was seriously injured while riding the lead tank car during a shoving movement on the industry lead track at the Chief Ethanol Fuels (CEF) facility in Lexington, Nebraska.¹ The UP switching crew was in the process of shoving 25 empty rail cars into the facility when the accident occurred. The conductor was struck when the lead tank car sideswiped a stationary trackmobile fouling the industry lead track.² (See figure 1.) Emergency medical responders airlifted the conductor to a hospital in Kearney, Nebraska. At the time of the accident, visibility conditions were cloudy with light precipitation; the temperature was 72°F.

¹ (a) Visit [ntsb.gov](https://www.ntsb.gov) to find additional information in the [public docket](#) for this NTSB accident investigation (case number [RRD25FR015](#)), including detailed factual reports about the circumstances of the accident. (b) All times in this report are local. (c) A *tank car* is a type of railcar used to transport liquid or gaseous commodities. (d) A *shoving* movement is the process of pushing railcars from the rear with a locomotive. (e) The *industry lead track* runs west and then north from the CEF facility to UP's Lexington Yard in Kearney Subdivision.

² (a) A *trackmobile* is an on-track vehicle used to move railcars. (b) *Fouling* is placing an individual or equipment on the track or in such proximity to the track that the individual or equipment could be struck by a moving train or on-track equipment.

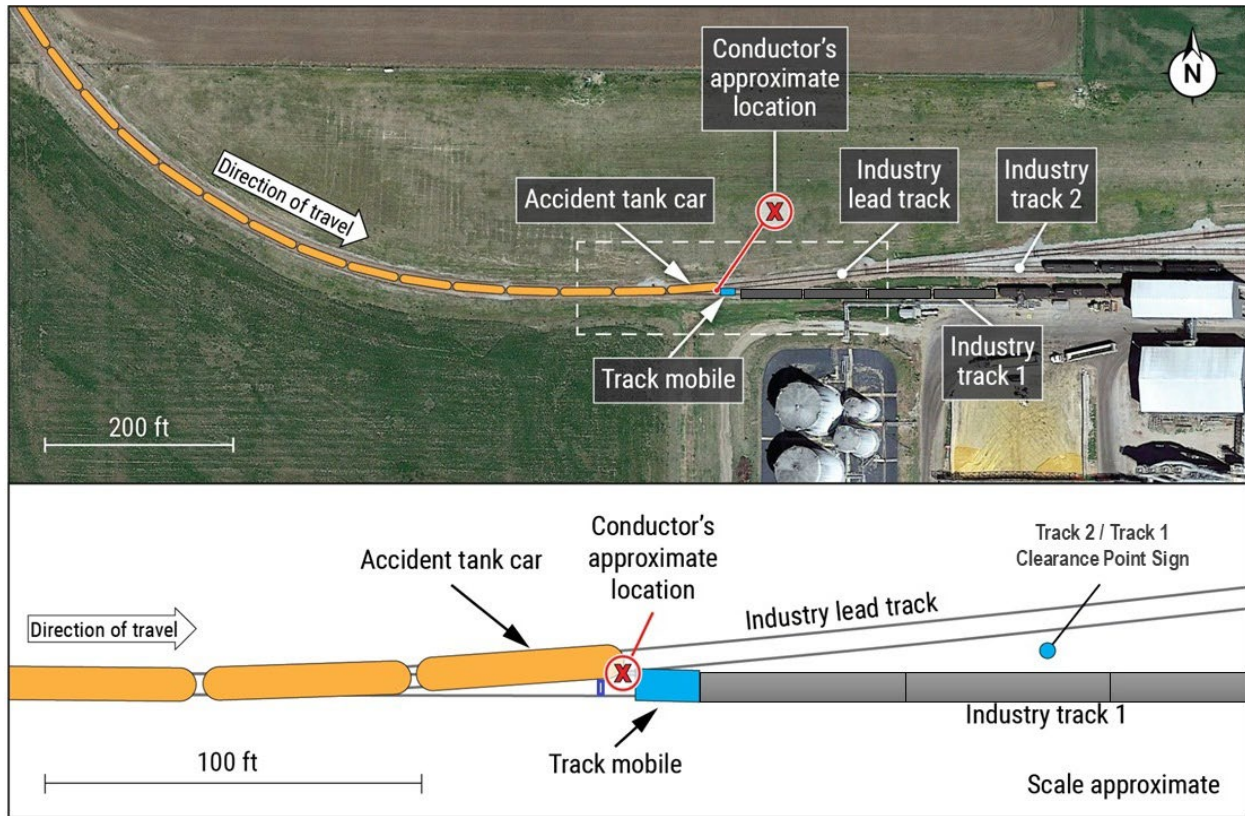


Figure 1. Overhead view of the accident site and diagram of the accident.

On the day of the accident, two CEF operators were switching tank cars on the industry tracks within the CEF facility using a trackmobile.³ (See figure 2.) The tank cars were being switched to accommodate loading operations by facility personnel. One of the operators was lining switches while the other was controlling the trackmobile from the ground with a remote control.⁴ The operator of the trackmobile had been hired by CEF about 3 weeks before the accident and the accident happened in the first week he was assigned to operate the trackmobile unsupervised. Before the accident, CEF's training for new operators consisted of up to 2 weeks of on-the-job training on the trackmobile or until determined proficient. This training does not include standard railroad operating rules and procedures.

³ *Switching* is moving railcars from one track to another track or to different positions on the same track.

⁴ *Lining switches* is aligning the movable rails or switch points with one track when a track diverges into two or more tracks to guide a train onto the desired track.



Figure 2. Exemplar Trackmobile at the CEF facility.

On the morning of the accident, the UP switching crew, which consisted of an engineer and the conductor, arrived at the CEF facility to pick up loaded tank cars from track 5 that were billed to depart. After picking up 25 loaded tank cars, the crew traversed the CEF lead track at 8:42 a.m. and departed the facility to return to Lexington Yard. The crew passed the trackmobile parked in track 1, which was not fouling the lead track at this time, while making this switching move.

About 11:41 a.m., the CEF operators finished their switching operation and returned the trackmobile to industry track 1, which is the loadout track and adjacent to track 2 to the south.⁵ This switching operation was completed by the CEF operators before the UP crew returned to the facility. When the CEF operators completed the movement, the trackmobile was attached to the west end of the tank cars in the loadout track and tied down about 78 feet west of the clearance sign and fouling the lead track. The purpose of this clearance sign was to identify the clearance point, or the location

⁵ A *loadout track* is the track where cargo or commodities are loaded into railcars.

where the equipment can safely be positioned so that it does not conflict with movement on the adjacent tracks.⁶

At 12:30 p.m. the UP switching crew returned to the CEF facility as they shoved 25 empty tank cars from Lexington Yard eastbound on the CEF lead towards track 2. The UP conductor was riding the tank car while protecting the shoving movement from the south side of the lead tank car (the right side in the direction of travel).⁷ During the shoving movement the lead tank car sideswiped the trackmobile that was positioned on industry track 1 and within the foul of the lead track. The conductor was positioned on the tank car in a position that resulted in his arm being pinched in the collision causing severe injury. By regulation, conductors are allowed to ride the lead car to protect shoving movements, but they must determine when it is safer to ride the car or walk to protect the move.

In an interview with National Transportation Safety Board (NTSB) investigators, the UP engineer stated that the conductor was giving him car counts as they shoved the lead railcar at 5 mph. The conductor's last announced car count cleared him to shove 10 car lengths. The conductor then gave the engineer a stop request over the radio immediately before the train he was shoving struck the trackmobile approximately 3 car lengths after the 10-car count. The train was moving at 4 mph on impact and stopped 32 feet after the stop request was given. During a reenactment of the accident, investigators noted that there was a clear line of sight to the track 1 switch and the trackmobile from 233 feet away. The conductor was approximately 233 feet from the trackmobile when he gave the engineer the 10-car count.

According to the General Code of Operating Rules (GCOR), before initiating a shoving movement, conductors must determine that the portion of track to be used is clear of conflicting movements and equipment fouling the track. Additionally, except when moving on a main track or on a track where a block system is in effect, trains or engines must move at a speed that allows them to stop within half the range of vision short of: trains, engines, railroad cars, men or equipment fouling the track, a stop signal, derail or switch lined improperly.

⁶ A *clearance point* is a location near the switch of a diverging track beyond which it is unsafe for railcars or railroad equipment to proceed because train movement on the adjacent track could collide with the railcar or railroad equipment. Railcars and railroad equipment on industry track 1 at the CEF facility were required to be positioned east of the clearance point.

⁷ *Protecting a shoving movement* is visually determining that the route is clear of obstructions and conflicting movements.

Analysis

The investigation revealed that the trackmobile was fouling the lead track and positioned beyond the clearance sign (identifying the clearance point or location where equipment can safely be positioned) located between the two tracks. CEF operators were not trained in railroad operating procedures such as not leaving equipment in the foul of other tracks. CEF's new hire training consisted of informal on-the-job training that focused on the operation of the equipment. CEF is an industry not governed by FRA regulations. Thus, CEF operators are not required to comply with the GCOR rules specifying that conductors must determine that the portion of track to be used is clear of conflicting movements and equipment fouling the track. CEF stated that they installed clearance signs with the purpose of aiding their operators determine where equipment could be positioned safely. However, in this case, the operators were not trained to identify where it was safe to leave equipment on track 1 such that it would not interfere with equipment on adjacent tracks.

During the shoving movement, the UP conductor gave the engineer a 10-car count into track 2 which suggests that he believed the track was clear for approximately 700 feet. The conductor was approximately 233 feet from the trackmobile at the time of this communication. Radio communication records did not capture any additional communication between the conductor and engineer about stopping for the trackmobile until just before impact. The absence of such communication indicates that the conductor thought the trackmobile was clear (not fouling track 2) or that he overlooked the trackmobile and was focused on the route into track 2 to determine if the switches were lined for the route.

In addition, the position of the conductor while riding the train to protect the shoving movement was high risk. This position created a close clearance hazard for the conductor as he was on the same side of the track as the trackmobile. Investigators reviewed the training records of the crew of train LFG 15 and found that the crew had been trained to perform their duties and should have been able to stop in half the range of vision of any obstacle on the track.

Probable Cause

The National Transportation Safety Board determines that the probable cause of the June 25, 2025, accident was the Union Pacific Railroad conductor's failure to control the shoving movement in accordance with the General Code of Operating Rules by stopping short of an obstruction that was fouling the industry lead track and not identifying the potential hazard created by riding the lead tank car on the side passing in close proximity to equipment on an adjacent track. Contributing to the accident was the improper placement of the trackmobile by Chief Ethanol Fuels personnel beyond the

clearance point, creating a close clearance hazard on the industry lead track, and the lack of standardized railroad operating rules training for those personnel.

Lessons Learned

Railroad conductors face increased risk of death and injury when riding equipment during shoving movements. Of the 20 conductor fatalities reported to the Federal Railroad Administration between January 2020 and July 2025, 14 involved conductors riding trains during shoving movements (FRA Safety Data, n.d.). Five recent NTSB investigations highlight the dangers of riding trains during shoving movements. In these accidents, conductors were killed during shoving move operations.⁸

To call attention to the risks posed when railroad employees ride shoving movements, the NTSB's safety alert, *Shoving Movements: Avoid the Risks* issued on November 5, 2025, discusses the steps conductors and railroads can take to increase safety during shoving movements.⁹

⁸ Follow the links for more information on these NTSB investigations: [RRD23LR007](#), [RRD23FR012](#), [RRD23FR016](#), [RRD24LR013](#), and [RRD25FR013](#).

⁹ The full text of the safety alert is accessible at: <https://www.nts.gov/advocacy/safety-alerts/Pages/SA-103.aspx>

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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 RRD25FR015. 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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